IN THE CIRCUIT COURT OF KANAWHA COUNTY
STATE OF WEST VIRGINIA

JAMES E. McCUNE, et al.,

Plaintiffs,

vs

THE AMERICAN TOBACCO COMPANY, et al.,

Defendants.

VOLUME II

CIVIL ACTION
NO. 97-C-204

The video deposition of ELBERT D. GLOVER, Ph.D., taken upon oral examination, pursuant to notice and pursuant to the West Virginia Rules of Civil Procedure, before Johnny J. Jackson, Registered Diplomate Reporter and Notary Public in and for the State of West Virginia, Thursday, September 23, 1999, at the Offices of Jones, Day, Reavis & Pogue, 31st Floor, Conference Room D., 500 Grant Street, Pittsburgh, Pennsylvania.

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ELBERT D. GLOVER, Ph.D. - DEPONENT

SEPTEMBER 22, 1999

EXAMINATION BY:

EXHIBITS IDENTIFIED:

VIDEOGRAPHER: We are now on the record.
BY MR. ROWLEY:
Q. Good morning, Doctor.
A. Good morning.
Q. What was it that you were just looking at before we went on the record?
A. The FTND.
Q. Could you get that out for me?
A. It has pharmaceuticals' names on it, and what I would like to do is scratch those out. That information is confidential. The questionnaire isn't, but the actual, this form in particular is confidential to the pharmaceutical company. I signed a confidentiality agreement.
Q. What pharmaceutical company is it?
MR. GOLDBERG: You don't neeed to answer that. Objection.
A. That's the point. If I tell you, then there is no sense in scratching it out.
Q. This is simply the form of the questions that are asked that is part of the process of assessing --
A. Correct.

Q. -- nicotine dependence?
A. Uh-huh.
Q. You need to wait until I finish my question before you answer.
The document that you are referring to is simply the form of the questions that are asked as a part of assessing nicotine dependence; is that correct?
A. Correct.
Q. The part of it that you feel is confidential is simply the name of a pharmaceutical company that is on the form?
A. Yes. It's confidential. I signed, when we do studies, I sign confidentiality agreements that I won't share what study we may, in fact, be doing, because of other competition and so forth.
So what I need to do is just scratch out the pharmaceutical companies or any reference to the study.
The questionnaire is the questionnaire.
Q. So this questionnaire in the document that you are referring to doesn't differ from the

questionnaires that are used within, with respect to work for other pharmaceutical companies; is that right?
A. Correct. There's some little alterations, some little subtleties among the questionnaires; but that's pretty much the same thing.

Q. For what pharmaceutical companies are you currently doing research?
MR. GOLDBERG: Objection if it is confidential. If it's not then . . .
A. Some of them are confidential as we speak, because the confidentiality doesn't end until we complete the study; and then there's others that we have already completed. And I can tell you about all the ones we have completed before.
Q. Which ones are in progress?
A. I just told you that the ones that are in progress I can't really tell you about those, but I can tell you about the ones that have been completed.
Q. Are these scientific studies?
A. Yes. They are clinical trials for

testing medications to see, in terms of pharmacological adjuncts for helping people quit smoking.
Q. Are they scientific studies that will reach scientific conclusions?
A. Eventually, yes.
Q. It's your testimony that these scientific studies that will reach scientific conclusions are secret?
A. No. That's not what I'm saying. It's when the test is actually going on you don't share with the competitors. And, basically, the pharmaceutical company has asked me to sign confidentiality agreements so other companies don't know what they are doing, because they are basically in competition.
When it is over with, it's published and it's presented and so forth, and everyone has access to it eventually. As a matter of fact, they encourage that. Any document that we signed is, when we get involved in these clinical trials is at the end we have to be able to publish that paper or we don't sign an agreement with them to actually conduct their research.

Q. Do you believe that there's anything wrong or unethical about keeping a scientific protocol or scientific data secret during the pendency of a study while the study is being conducted?
MR. GOLDBERG: Objection.
A. That's a confidentiality agreement that I signed. I don't particularly maybe see it as dangerous, but I'm not in the business world. I don't compare, I don't try to, you know, I'm not competing with them or whatever.
Basically, there's a confidentiality agreement that everyone signs across the country that's involved in research, because it is confidential, until the study is complete.
Again, once it is complete, it's submitted to the FDA and it's submitted for publication and presentation; and everyone has access to it thereafter. So there's nothing particularly secret about it or whatever. It's

during the actual time of the study that it's going on.
Q. You wouldn't sign the secrecy or confidentiality agreement if you thought it was

unethical, would you?
A. I wouldn't sign it, no. Not if it was unethical, no.
Q. Why don't you get the document out and scratch out the name of the pharmaceutical company, and we will get it marked.
A. Okay.
THE DEPONENT: If I can have a --
MR. GOLDBERG: Can you scratch it out?
THE DEPONENT: I need a big, black Marks-A-Lot or something, or maybe cutting it out or something would be easier.
MR. ROWLEY: Let's go off the record while we resolve this.
(Off the record.)
(Deposition Exhibit No. 13 marked for identification.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Let me hand you Exhibit 13, Doctor. Is that a scientific document?
MR. GOLDBERG: Objection, vague.
A. Scientific, what do you mean by

scientific?
Q. Doctor, are you familiar with the English word "scientific"?
A. Yes, but it has a lot of meanings to a lot of different people. So if you could just -- Science can mean a lot of things. If you could share the operational definition, I might tell you.
Q. Using whatever definition you as a scientist use in your day-to-day work, is that a scientific document or not?
A. I would say that virtually every Tobacco Research clinical trial conducted for the Food and Drug Administration, in fact, uses this. I would say that it was probably the most widely-used test for nicotine dependence that's out there. So based on that, and that it has been published in refereed journals, I would say that, yes, it probably is a scientific journal.
Q. Is Exhibit 14 a scientific document?
A. Again, the FTQ, Fagerstrom Tolerance Questionnaire, was developed many years ago and has, in fact, been published. And since it has been published in professional refereed journals, I would venture to say that it, in fact, is probably

a scientific publication.
Q. We went off the record there for a few minutes, and you did some ripping and tearing of those scientific documents. Why don't you hold up Exhibit 14 and show the camera there exactly where you ripped and teared?
MR. GOLDBERG: I want to put an objection on the record. These documents were not

properly requested. As a courtesy to you, they were faxed here without the doctor having a chance to examine them.

They had confidential information related to the identity of the drug company for which that particular study was being used, being undertaken; and the only thing that was deleted from these forms by ripping was the identification of the drug company.

Q. Doctor, you don't have a problem in this case with a judge or the jury knowing what information you ripped or tore off those documents, do you?

A. There's no information other than the name of the pharmaceutical company. And I just signed a confidentiality agreement that we're doing

that. And that's primarily because they don't want their competitors to know what they are doing.

It's very simple. It's something that you could retrieve from the literature anytime. You could get, I could fax you another one. You could call and ask colleagues and they could send it to you. So it's very simple to retrieve, and you can do it.

You are making a big thing out of the ripping and the tearing as though something clandestine is occurring, and it's simply not. All it is is the pharmaceutical company asked me to keep this confidential so no one would know what they are doing. It's real simple.

Q. Hold that up to the camera.

A. Sure.

Q. Show is where you ripped --

A. I actually tore the name of the company here, and then the name of the company was down here.

Q. Was the, without telling me the name of the company, I'm not asking you the name of the company, because I understand you are refusing to tell us that, but was the name of the company

reflected on there because they faxed, that company faxed that form to you?

A. No. They did not fax it. This is a case report form that we're using in our clinical trials. And last night, at your request -- I could have sent it to you later or whatever and we could have properly taken care of this -- but you actually requested one of these, and you seemed to have a sense of urgency.

So, in fact, I called late last night and this morning and got it. And the person that faxed it actually went into the clinical case report forms of one of the studies and faxed it to me. They could have very easily have faxed one that was not there. I just wasn't clear when I requested it.

Q. Could you hand me the ripped and torn documents, please? Thank you.

MR. GOLDBERG: Objection, move to strike. There will be no more documents produced at your request unless they are properly produced

from now on.
Q. Did you, Doctor, talk with or confer with the plaintiffs' lawyers at any time between

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the time that we stopped the questions yesterday during the deposition and the first question that I asked you this morning?
A. By "conferred," what do you mean by conferred?
Q. Did you talk to them?
A. Sure.
Q. Did you talk to them about the deposition?
A. He told me two things. Just told me to have a good time and relax, is what he said.
Q. When did you talk to him, last night?
A. I talked to him when we left, from the moment. We don't walk in silence or whatever. We were talking a lot about travel, because we both joy traveling. Talking about the millennium and a whole variety of things, but --
Q. I'm not interested in any of your conversations with him that don't relate to --
A. I would like to finish before you --
Q. I thought you were done. Go ahead.
A. I had not finished.
I have a lot of, we had a lot of conversation. And that's, I guess you just need to

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be specific when you said, Did you have contact or talk? Of course, we did. We talked about a lot of things. If you can just be really specific to something, I could answer yes or no very easily.
Q. Did you talk about any of the testimony that you gave yesterday?
A. Like I said, the only things he told me were two things. He said, Just relax and have a good time. I think he may have said, You are doing fine, or something like that.
Q. Did you talk about any of the specific testimony that you gave yesterday?
A. No. If that's all he told me, I can assure you that we didn't talk about specifics of the testimony.
Q. Did you talk about anything that is in your report or that should have been put in your report?
A. No. We didn't talk about that at all.
Q. Did you talk about any of the questions that he felt might be asked of you today?
A. No. We didn't talk about that at all.
Q. Did you talk about any work that you might do to prepare for today?

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A. No. We didn't. I was trying to think. No. We didn't talk about, I can't think of anything that we, nothing that was really about the trial or this deposition or whatever. He basically just said to relax.
Q. Did you ask him any questions about the deposition or your testimony or the subject matter of the lawsuit?
A. No. I did not.

Q. Did you drive home last night, or did you stay here in Pittsburgh?
A. I stayed in Pittsburgh.
Q. Did you review any documents that relate to the lawsuit last night?
A. No. I did not.
Q. Do you have any -- Where are staying? Well, I don't care. I don't care. Don't answer that. I don't care about that.
At the wherever you stayed, do you have any documents that relate to this lawsuit? That was the point of my question. Go ahead.
A. Documents, I brought everything that you, that was requested of me with me. So I don't have any documents.

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Q. So wherever you stayed, there were no documents there that you didn't have with you in the deposition room and showed to me yesterday; is that correct?
A. Uh-huh.
Q. Did you talk with anyone last night about the case, the lawsuit, or any issue in the lawsuit or your testimony?
A. Yes. I did call my wife.
Q. Did you talk with your wife --
Well, let me ask you, is your wife a medical professional?
A. She is an addictions counselor, and she works in the Tobacco Research Center.
Q. What's her medical training or background?
A. She is not a medical. She is certified in alcohol and substance abuse, and she's a counselor and actually coordinates the Tobacco Research Center in Morgantown.
Q. Are you board certified?
A. No. I just, for the maybe 20th time, yesterday I said it several times, board certified basically means physician, and I'm not a physician.

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Q. And you're not board certified in any sense of the phrase "board certified"?
A. No.
Q. Believe me, I'm not interested in any personal conversation that you may have had with your wife; and please do not tell me about any personal conversation that you had with your wife, because I don't consider that to be any of my business at all.
However, if you talked about the substance of your testimony or asked her for her advice on scientific or medical or addiction issues, I am interested in that.
Did you talk with her about the deposition, the substance of the deposition or the substance of your testimony?
A. I guess I'm not sure what you mean by "the substance." We did talk just briefly about it. I can tell you exactly what we said, but I'm not sure if that's substance.
Q. Is this something that you are entirely comfortable telling me about?

A. Yeah. We didn't -- I mean, yes.
Q. I don't want to ask you about

something you are not comfortable telling me about. Go ahead. And if you are comfortable and only if you are comfortable telling me about it, please do.
(Speaker phone interruption.)
MR. ROWLEY: Let's go off the record.
(Off the record.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Tell us about that discussion, Doctor.
A. Yes. I called my wife and she -- I think maybe we talked about what was going on at the center and so forth -- and she said, How is it going? And I basically told her that it was really interesting; it was really exhausting; and that I thought that the person asking the questions, I said, Well, he is rolling his eyes and doing a lot of unusual types of things and trying to distract me. I said, It's really tough.
And I think what she offered in terms of advice, period, was, Just remember, you're the expert. And then we went on to something else. I think she said, It's the advice you give me all the time. Remember, you are the expert.

So that was enough. And I remembered, yes, that I needed to come in here and become, be a little more confident in sharing information.
But that's pretty much the extent of the conversation.
Q. The question, of course, was regarding the substance of your testimony or your opinions. I'll move to strike that answer as not responsive to the question.
Doctor, let me hand you what's been marked as Exhibit 3. Is that a scientific paper that you wrote, sir?
MR. GOLDBERG: Excuse me for one moment. Do you have a copy, please?
MR. ROWLEY: I do not. But please feel free to look at it before he looks at it.
MR. GOLDBERG: All right. Then I might. Let me look at it for one minute.
Okay.
A. Yes. I was part writer in this.
Q. You took part in writing that paper and conducting the research that formed the basis of the paper; is that correct?
A. Actually, what this was is, it was a

thesis; it was a master's thesis. Suzanne Lane was a master's student at East Carolina University, and I was her major professor. And we completed, she completed the study and really conducted and did virtually all of it. I just guided her, because I was her advisor. And when it came to publishing, she was not interested in publishing.
So, basically, I took all of her work that was put together and wrote it and submitted it. I took care of the actual submission portion,

where she actually carried out the study.
Q. You are the first named author on that paper, are you not?
A. Right.
Q. What's the first word in the title of that paper, Doctor?
A. "The."
Q. What's the second word?
A. "Incidence."
Q. Thank you, sir.
By the way, Doctor, this was published in the spring of 1994; is that correct?
A. Yes. Correct.
Q. Thank you, sir.

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Doctor, if someone smoked 101 cigarettes over a period of 30 years, approximately how many cigarettes would that be a year?
A. Why don't you do that. You have got a calculator.
Q. The way we would do that would be to divide 101 by 30; is that correct?
A. To get per year?
Q. Yes, sir.
A. Uh-huh.
Q. That's approximately three. It's 3.3. It's approximately three cigarettes per year; correct?
A. Yes.
Q. A person who smoked three cigarettes per year for 30 years would meet the definition of smoker that you put in your report for this case. That's true?
A. If they were currently smoking, yes.
Q. If they had smoked a cigarette recently, that's true, isn't it?
A. Yes.
Q. Can you name for me, Doctor, any epidemiologic study that purports to demonstrate a

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statistically-significant increased risk of any smoking-associated disease among persons with a smoking history of three cigarettes per year?
A. That's not the type of work that I typically read or participate in or whatever. There may be some; but when I look at the literature, that's not what I'm looking for.
Q. That question is beyond the scope of your expertise?
A. Yes.
Q. And when you came up with the definition of smoker that you put in your report, you did not in any way consider whether a person who met that definition had a biologically-significant exposure to tobacco smoke?
A. I was asked to, what is the operational definition of a current smoker. And I gave the definition of a current smoker that's used by the FDA, CDC -- it's used by virtually everyone -- what constitutes a regular smoker.
MR. ROWLEY: I move to strike that as non-responsive. Please read the question back.
REPORTER: "And when you came up with

the definition of smoker that you put in your

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report, you did not in any way consider whether a person who met that definition had a biologically-significant exposure to tobacco smoke?"

A. That was not what I was asked to do, and I thought I answered that once before. I was not asked to do that. I was asked to give a definition of a smoker, and that's what I provided.

Q. Since you were not asked to do that, you, in fact, did not do that?

A. No. I don't believe so.

Q. If a person, if you were to see a person for purposes of assessing dependence, and that person had a history of smoking of three cigarettes per year, and was consistently, year after year, able to smoke only three cigarettes per year, that is to say, have one cigarette every four months, would you consider it justified to spend money assessing whether that person was dependent on nicotine?

A. Typically, when someone, rarely no one would come in that's, the hypothetical situation that you're expressing there is really unusual, even though for maybe research purposes they may be classified as a smoker. But no one like that would

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ever come into the center, probably. At least I don't remember ever recalling one. And it wouldn't take just two or three basic questions. They could fill out the Fagerstrom Tolerance Questionnaire, and we could tell very quickly that they were possibly non-dependent.

So we would assess that very quickly. We wouldn't need the entire battery of tests to do that. Even though they may be counted supposedly as a smoker in terms of our operational definition of what a smoker is, that's simply, I mean, I think you're really exaggerating and trying to give extremes. That's not very realistic in the way that we would handle that person.

Q. So a person who smokes that much is not a very realistic example of a "smoker"?

A. No. He's an operational definition for a smoker. You're putting words in my mouth. That's the operational definition for a smoker.

Remember, we are treating the nicotine-dependent patient. If someone is smoking, it takes a while, it's on a continuum when a person might, in fact, become addicted. They don't get addicted after one cigarette. I can't tell you

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where it happens, because there's a tremendous amount of difference in the way individuals absorb and metabolize nicotine. There's just a lot variability initially as to when someone may get addicted. And that's why we, in fact, use all the tests that we do to be able to say that they are or are not addicted.

Q. You say, Doctor, that there is a lot of variability as to whether someone may be addicted. What does that mean?

A. Some variability, in other words, just

as an example, people can be addicted at a variety of points. Some can be heavily addicted and some can be not as addicted.

That Fagerstrom Tolerance Questionnaire, that's exactly what it does. It's supposed to be able to tell us to a certain degree that, in fact, a person is highly dependent or they are low dependence.

And that's basically what I'm getting at. Some people can be high; some can be low. But they're basically both dependent. It's real simple. It's just like all water freezes at 32. But, obviously, 10 is colder than 20, but at 32

it's all frozen. So, in effect, they're both addicted. One just happens to be lowly addicted, and the other one is more highly addicted.

Q. Doctor, you acknowledge that not all smokers are addicted?

A. That's probably, yes, I would say that's probably true.

Q. Not all smokers are dependent; correct?

A. Yeah. I use the words interchangeably, yes, and I would say that's probably true.

Q. If all smokers were addicted or dependent, there would be no point in assessing whether different smokers were addicted or dependent?

A. Could you repeat the question, please?

Q. If all smokers were addicted or dependent, there would be no point in assessing on an individual basis which smokers are dependent and which smokers are not?

A. No, not necessarily. We have to be able to figure out whether they're dependent, first of all. Then once they are dependent, whether they

are, in fact, high dependence or low dependence, then what we're trying to do is trying to match them up with a treatment.

We have to take a look at what treatments are available, because some have been found to be a little more effective for others in the various treatments. So then thereafter we match them up with the individual treatments.

But everyone that is a smoker basically should be assessed whether they are dependent or not.

MR. ROWLEY: Move to strike as non-responsive.

Q. Doctor, if all smokers were dependent or addicted, there would be no point in assessing on an individual basis which smokers are dependent and which smokers are not; that's true?

A. Yeah, I have said -- That's not true. Again, I am into treatment. That's my expertise. What we are trying to do is figure out whether they're high- or low-dependent smokers. So even if they were all dependent, we'd still have to do the assessing so we could figure out if they're high or low to match them up with a treatment that, in

fact, may be more efficacious for them. It's real simple. It's not as complicated as you are making it.

MR. ROWLEY: Move to strike that as non-responsive.

Q. Do you know who Mr. McCune is?

A. I didn't know who Mr. McCune was yesterday, and I still don't know today.

Q. I don't believe I asked you that question yesterday.

Do you know anything about Mr. McCune's background?

A. No. I don't know Mr. McCune.

Q. Do you know anything about Mr. McCune's smoking habits if, in fact, he smoked?

A. No. I don't know who Mr. McCune is, so I wouldn't know anything about his smoking habits.

Q. Did Mr. McCune smoke?

A. I don't have any idea.

Q. What risk factors for smoking-associated disease does Mr. McCune have?

A. I don't know Mr. McCune, so I would have no idea.

Q. Is there any attribute of Mr. McCune's smoking history, his attitudes, his perceptions, his experiences, his motivations, or any other attribute of his being that is representative of any other smoker within the State of West Virginia?

A. I don't know the individual we are talking about, so all of that, I have no idea whether he is representative or anything. I'm not familiar with Mr. McCune.

Q. The Plaintiffs' lawyer didn't ask you to assess that issue; correct?

A. No, he did not.

Q. Therefore, you did not assess that issue?

A. No.

Q. Therefore, you have no opinions regarding that issue?

A. No.

Q. By "no" you mean you have no such opinions; correct?

A. That's what I mean when you ask if I had an opinion and I say, No, it usually refers that, no, I did not have any opinions.

Q. Doctor, can you tell us what

percentage of the generally-accepted biologically-relevant exposure to tobacco smoke your definition of smoker comprises?

MR. GOLDBERG: Objection to form. So vague it is . . .

Q. Go ahead, Doctor.

A. Could you get either repeat the question or be a little more specific?

MR. ROWLEY: Could you read it back, please?

REPORTER: "Doctor, can you tell us what percentage of the generally-accepted

biologically-relevant exposure to tobacco smoke your definition of smoker comprises?"

MR. GOLDBERG: Same objection to form, vagueness.

A. Yes. I'm not really quite sure what you want there, to be perfectly honest. So, obviously, that being the case, I don't guess I can provide it. I'm not sure what you're asking.

Q. You acknowledge, sir, even though you don't know what the level is, that there is a level of smoking that is biologically significant and a level that is biologically insignificant? You

acknowledge that?

A. Yes, I would probably, would acknowledge that.

Q. Does your definition of smoker include levels of exposure that are biologically-insignificant or unimportant?

A. I did not select that definition based on that, so I would say have no idea. I basically was asked to identify what a smoker is.

Q. Can you tell us how much lower your definition of smoker is than the biologically-relevant level of exposure?

A. Again, I was just asked to provide the --

MR. GOLDBERG: Object to form.

A. I was just asked to provide the definition. I was not asked to look into that or delve into that whatsoever. So I have no idea.

Q. What, Doctor, is the empirical probability that a smoker who year after year is able to go four months in between each cigarette is addicted?

A. I could not provide that information. I don't, you know, a cigarette every four months, I

don't, I have no idea.

Q. Do you agree with me that it's a very low probability, using your professional judgment?

A. I would say, obviously, the lower, the fewer that you smoke, and one every four months I would venture to say that is probably pretty accurate. I mean, I don't know.

Q. All right. That's fair enough. Fair enough.

Would you acknowledge then that your definition of smoker includes smokers who are very, very unlikely to be addicted?

MR. GOLDBERG: Objection to form. And the question --

Q. Go ahead, Doctor.

MR. GOLDBERG: -- misstates his testimony.

Q. Go ahead, Doctor.

A. Could you repeat the question?

REPORTER: "Would you acknowledge that your definition of smoker includes smokers who are very, very unlikely to be addicted?"

MR. GOLDBERG: Before he answers, do you have Exhibit 11 handy, please?

MR. ROWLEY: I'm not asking about Exhibit 11.
Q. Doctor, can you answer the question or not?
MR. GOLDBERG: Eleven is what he said was his definition.
A. Would you repeat the question?
REPORTER: "Would you acknowledge that your definition of smoker includes smokers who are very, very unlikely to be addicted?"
A. Possibly. But it's the way that they would answer it. Most people that have smoked one cigarette every four years, or something in that extreme example that you have presented, probably would not see themselves as a smoker, so would not respond accordingly on the survey. In other words, if they were specifically asked about the various questions, whether they are currently smoking, even though they may have had one cigarette yesterday or today, I don't believe that they would respond affirmatively on that. I don't see themselves as calling themselves a smoker. Usually that's a, that's the first step.
Q. What you're saying is that there are

smokers who fit the definition of smoker reflected in Exhibit 11 who would not even consider themselves to be smokers?
MR. GOLDBERG: Objection to form.
Q. That's what you just said.
MR. GOLDBERG: It misstates his testimony.
Q. Doctor, are you going to give your own answer or adopt counsel's answer to that question?
MR. GOLDBERG: Objection. Move to strike.
Q. Answer the question, please.
A. Could you repeat the question?
Q. Doctor, your definition of smoker as reflected in Exhibit 11 includes people who would not consider themselves to be smokers. That's what you just said; correct?
MR. GOLDBERG: Objection, misstates --
A. Could you not put words in my mouth and just ask me the question? I think it would be a lot easier. In other words, what I said, could you just ask me the question? It would be a lot easier, because you use different words sometimes than what I say.

Q. I will ask you again. It is true, Doctor, that your definition of smoker as reflected in Exhibit 11 includes people who would not consider themselves to be smokers.
MR. GOLDBERG: Objection, misstates his testimony.
A. What you have done is taken an isolated example completely -- and 30 years ago, I could almost assure you that even though that may or may not fall within that operational definition of what a smoker, it probably would. But you picked the isolated example to sort of try to prove a point. What is really happening to those people,

I could almost be positive that those people, in fact, in these surveys are not part of that group that considers themselves possibly a smoker. In other words, 30 years ago, I think you're really stretching the definition, is what you are doing.

Q. Let me ask you the question in a different way and see if I can get an answer.

MR. GOLDBERG: Objection, move to strike.

Q. Does the definition of smoker in Exhibit 11 include people who would not consider

themselves to be smokers, in your opinion?

A. I don't know. I didn't actually do the survey. Basically, you would have to talk with CDC with that. They are the ones who actually do the surveys, and who is eliminated and who is included and so forth.

All I was asked, to provide a definition of what a current smoker is. And a current smoker is, in fact, what I said it is. I don't know if those would be included or if they were included. That's for CDC. They are the ones that, in fact, use this definition that everyone basically adopts.

Q. So you don't know whether your definition of current smoker in Exhibit 11 includes people who would not consider themselves to be smokers? Is that true?

MR. GOLDBERG: Objection. Misstates his testimony.

Q. Is that true or not?

A. Would you ask that again?

Q. You don't know whether the definition of smoker contained in Exhibit 11 includes individuals who would not consider themselves to be

smokers? You don't know?

MR. GOLDBERG: Same objection.

A. Yeah. I mean, I don't know, again, I don't know what the CDC, what the history is of the survey or who they include or don't include.

In many surveys, invariably when people are, in fact, the data are collected, people draw certain lines at certain points and say, Well, if someone did not respond on a survey the whole survey is eliminated.

So there's some specific little protocols that take place that I was just not privy to when this was developed. I just know the operational definition for what a smoker is. It's an individual who would smoke a hundred or more cigarettes in that lifetime and is currently smoking everyday or some days. That's what is considered a smoker, and that's what I was asked to provide.

You are asking about historical questions and background and so forth and what CDC and how they came up with this, and I don't have any idea who was included or not included.

MR. ROWLEY: Move to strike as not

responsive.

Q. Does that mean that you do know or you don't know whether the definition of smoker, current smoker in Exhibit 11 would include people who do not consider themselves to be smokers?
A. I just answered that question a while ago, and I'll answer it the same way. To me that's an answer. It may not be an answer that satisfies you, but that's the answer. I don't know how this was developed or who was included in that survey.
That's the definition that most people use to constitute a smoker. And that's what, in fact, people use.
Q. Does the definition in Exhibit 11 include people who don't consider themselves to be smokers?
A. For the third time --
MR. GOLDBERG: Objection, asked and answered.
A. For the third time, I think I have answered that.
Q. Doctor, just because your mouth moves and noise comes out after I ask a question doesn't mean that you've answered the question.

MR. GOLDBERG: Object and move to strike. And if you continue to make comments like that, then we will ask the Judge to get involved at this point. That's highly inappropriate, for you to say things like that.
MR. ROWLEY: I move to strike his answer. And we are likely to get the Judge involved unless this witness starts at least attempting to answer questions.
MR. GOLDBERG: The witness has answered the question. And if you continue to make comments like you have made, we will recess this deposition until the Judge rules on it.
Q. Doctor, yes or no, do you know whether the definition of current smoker in Exhibit 11 includes smokers who have not, includes people who would not consider themselves to be smokers, yes or no?
A. Again, I have told you that I do not know how CDC developed the questionnaire and what they put together, whatever.
And this is the fourth or fifth time that I have responded to this.
And I don't know the historical

perspective or who they included or not included.
The definition to me is very simple and straightforward. In other words, if they smoke a hundred or more cigarettes in their lifetime and are currently smoking, then they are considered a smoker. And that's what I come up with what a current smoker is.
And I think I have answered that the fourth or fifth time, maybe not to your satisfaction. But that's my answer.
Q. Doctor, do you sometimes consider a person who does not himself believe he is a smoker to be a smoker?
MR. GOLDBERG: Objection, asked and

answered.
A. Would you repeat the question?
Q. Do you sometimes believe or reach the conclusion that a person who himself does not think he is a smoker is a smoker?
A. Sure. There's a lot of people that don't consider themselves smokers. I mean, a perfect example, for years and years, or many years ago, I know a lot of people that would come in and say, Oh, no, I can quit anytime want to. I'm not

really a smoker. I'm just enjoying this, or whatever. So when we asked them to quit for a day or two, they experience, that they can't quit, why because they are experiencing withdrawal symptoms.
So that individual perceives themselves as maybe a non-smoker, they just enjoy a cigarette every now and then, when in reality they were truly addicted, because they experienced withdrawal symptoms when they tried to quit.
Q. Doctor, what are the other generally-accepted definitions of current smoker that are found in the peer-reviewed scientific literature?
A. I don't know the other definitions. I just know the one that we use. There is no reason to really embrace any of the others, because those are typically not the ones that we use or are familiar with.
Q. Have you compared the definition that you selected for use in this case with any other definition that appears in the peer-reviewed scientific literature?
A. Again, I don't embrace any of the others, or whatever. We usually go with what the federal government is doing because I think they

possibly have gone, possibly they have gone through and tested and looked at it, and that's the one that they use. And when people want to compare apples to apples, we naturally try to use a similar definition.
If I used a different definition I could not compare any numbers, or no one could, to any of the current numbers that are being collected by CDC.
Q. Did you make the comparison that I described or not?
MR. GOLDBERG: Objection, asked and answered.
A. I guess I'm not -- What comparison are you referring to?
Q. Do you remember the question that I asked? You just got done answering it. Do you remember the question?
A. Yeah. Well, if I just answered it, why am I answering it again?
Q. Do you remember the question that I asked that you claim you just answered?
MR. GOLDBERG: Objection. This is not a memory test. Would you please read back the last

question and the last answer?
MR. ROWLEY: No. There's a question

pending right now.
Q. Doctor, you just got done --
MR. GOLDBERG: Objection --
MR. ROWLEY: Excuse me.
MR. GOLDBERG: Just a minute. If there is a question pending, it is unclear. We would like to have either the question re-asked or re-read, one or the other. Either re-ask it re-read it.
MR. ROWLEY: Please read back the very last question that I asked.
REPORTER: "Do you remember the question that I asked that you claim you just answered?"
MR. ROWLEY: Yes.
A. Could you repeat the previous question? I don't, at least I'm entitled to try to, the question that I thought that I responded to it.
Q. Does that mean that you don't remember the question?
MR. GOLDBERG: Objection.

A. No. I'm asking that I want clarification on the question.
I think you are playing word games as usual. I think if you would back up and ask me the question -- and I am entitled to have the question repeated. I don't know why you continuously, what you're attempting to do. But it seems to me -- let me finish -- I think you, in fact -- I should be allowed to hear the question again. Because your questions are rather lengthy and sometimes deliberately confusing and incredibly vague.
So I think it is very important, if I want to be accurate, that I be allowed to hear the question again. So if you want me to respond to it, then you should, in fact, give me the question again, because I thought I responded to it.
MR. ROWLEY: Move to strike the speech.
Q. Doctor, tell us which, if any, of the alternative definitions of current smoker you compared the definition contained in Exhibit 11 with.
A. I told you before, and I answered that very directly, and I think if you go back and look

in the record, I, in fact, answered that. I did not compare it to any because I don't embrace any of the other definitions. The definition that we use is the one that the federal government uses, and the majority of the people out there, in fact, that are doing research use. It's the one that I gave you. That's what I stated before and I've stated again.
Q. Doctor, you have called nicotine dependence a powerful addiction; is that right?
A. Yes.
Q. Compared to what other addictions is nicotine addiction a powerful addiction?
A. I think when you take a look at the literature, virtually everyone, you know, the

Surgeon General's report, and several people have mentioned, they typically will compare nicotine to cocaine or alcohol or heroin. And I would see that as a powerful addiction. I couldn't tell you which one is first, second, third or fourth, or whatever, but I would see that as a powerful addiction.

MR. ROWLEY: Move to strike as non-responsive.

Q. Doctor, compared to which other

addictions is nicotine a powerful addiction, and by that I mean which addictions are not powerful addictions?

A. Again, I responded to that question, and I answered it very directly. I just told you when you are reading the literature nicotine is continuously being compared to heroin, cocaine and alcohol addictions. Let me say it again. Cocaine, alcohol and heroin addictions as compared to that, that to me would make it a powerful addiction. As far as other drugs, they don't bring those up, but it is always mentioned in the very similar breath. That to me is a very powerful addiction.

MR. ROWLEY: Move to strike as non-responsive.

Q. Doctor, can you name one addiction that compared to nicotine is not powerful?

A. One addiction that's not. That's, again, I'm talking about the addiction, I said that it was a powerful addiction. I would say that it was not less powerful than or whatever. I think you're playing little word games. I told you where it is included and where I got that statement. The statement, I think most researches will acknowledge

that it is considered a powerful addiction in the group that it is included in.

MR. ROWLEY: Move to strike that as non-responsive.

THE DEPONENT: Could we take a break here?

MR. ROWLEY: Any time you need a break we will take a break, sir.

(Break.)

VIDEOGRAPHER: We are back on the record.

BY MR. ROWLEY:

Q. Sir, have you ever personally reviewed a BRFSS questionnaire?

A. A what questionnaire?

Q. BRFSS.

A. What is a BRFSS?

Q. Let me back up a little bit. Do you know what a BRFSS questionnaire is?

A. No. I don't believe I have heard the term.

Q. Are you familiar with the acronym BRFSS?

A. No.

Q. Never heard of it, as far as you know?

A. May have heard of it, but it's, I don't, it's nothing that's coming to mind.

Q. Is the definition of smoker that is contained in the BRFSS questionnaires the one that is reflected on Exhibit 11?
MR. GOLDBERG: Objection to form, unless you show --
A. May I see --
MR. ROWLEY: Excuse me. What is the objection? What is the form of --
MR. GOLDBERG: You asked the witness about something he says he doesn't recognize. And unless you to show him a document. You can't proceed with that line of questioning.
THE DEPONENT: Could I see that?
MR. ROWLEY: There is Exhibit 11.
MR. GOLDBERG: No, no. You said BRFSS questionnaire.
A. Could I actually see that? I don't know if that, are you referring to the behavioral? I don't know if that's the acronym, but it's got a whole bunch of letters, and I've never heard anyone really call it BRFSS before.

But if that is the behavioral, what is it, the behavioral risk factor surveillance or something like that. I'm not really sure. If I could take a look at it, I could, it would be a lot easier to say, because I don't recall it right off the bat. You are saying BRFSS. I'm not really quite sure what that means or is. If you could show me one, it would sure be helpful.
Q. I don't have one with me, Doctor.
Do you know what BRFSS stands for?
A. B . . . No, no. BRF --
Q. FSS. Do you know what --
A. I think that's the surveillance survey, I believe. I just never had heard the BRFSS before.
Q. What do you think BRFSS stands for?
A. I don't, I couldn't give you the exact word for word.
Q. What is the definition of smoker contained in the BRFSS survey?
MR. GOLDBERG: Same objection.
A. I don't have any idea.
Q. Assuming that BRFSS stands for Behavioral Risk Factor Survey System, do you know

what definition of smoker is used in the BRFSS --
MR. GOLDBERG: Same objection.
Q. -- survey?
A. No, I do not.
Q. Doctor, you said you got your Ph.D. from Texas Woman's University?
A. Correct.
Q. Is Texas Woman's University still in existence?
A. Yes.
Q. Was their Ph.D. program accredited when you went there?
A. Yes. It was actually one of the better Ph.D.s in the country in terms of health science and health education. As a matter of fact, when I was looking at programs, the one closest to

it that was equal at the time is, I would have had to go to the University of Tennessee.

They have a huge nursing, physical therapy, a lot of health sciences in general. So it was actually one of the better programs in the country, you know, at that time.

Like I said, I would have had to have gone to Tennessee. And I thought that was

inappropriate, for me being in Texas to go to Tennessee. So I actually put, submitted my application and was, in fact, admitted.

Q. What is your specific basis for asserting that it was one of the better programs?

A. When I went through the catalogs and looked at it and talked to individuals, it was, basically, people said you get a wonderful quality education there, that it was, in fact, good. And I was told in looking that the only thing that was comparable was probably going to the University of Tennessee. And I thought that was a little too far away from home at the time. So I chose Texas Woman's University.

Q. Had it been ranked by some professional organization?

A. No. I don't remember any rankings of any health science, health education programs in particular at that time.

Q. Are the criteria that you use to assess whether someone is dependent on nicotine at the Center published anywhere?

A. I don't know if it is published per se as much as all the surveys and questionnaires and

everything that we use is readily available in the literature.

Q. Is the specific combination of surveys that you use and the other information that you gather in assessing that issue published anywhere?

A. I think several years, I'm thinking probably published, probably not. I'm trying to recall. don't think we have actually published, or I've published an article relative to that.

Q. As far as you know, that specific combination of questions and tests and inquiries is not published as an established set of criteria in the peer-reviewed literature. Is that true?

A. All individual tests are, and we use about three times more than the average person would. All of those tests, and I think -- where is that list here. I will repeat them to you again. Like the FTND, the FTQ, the number of cigarettes, the first cigarette in the morning, CO levels, cotinine levels, nicotine levels, and you talked about duration. You look at all of those things.

All of those have been looked at individually in various things. We have just tried to put them all together. It's very comprehensive

in the way that we determine what an addiction is. Again, that comes from just having a lot of experience, having done 25 years. We have never put them all together and published it in that

sense. But every one of those has been published or been referred to in the literature at one time or another.

Q. In assessing individuals, why don't you do just one of those things? I don't understand.

A. Well, you need to make sure. You want to, when you are working with someone, you want to be able to make sure that they, in fact, number one, are addicted at the level of addiction that they are, and to be able to see what, in fact, is desirable for this person. So we do a variety of series of tests just to make sure. I mean, some of this is just basic information that we collect. So we look at a whole variety of things.

Q. Why is that important to make sure?

A. You just want to be accurate. In other words, if someone is a high-dependence person versus a low, you don't want to give them a medication that is a four-milligram gum when they,

in fact, may only require a two-milligram gum; or you may not want to put them on a nasal spray as opposed to giving them an oral inhaler, because some of them are recommended for high dependence and some for low dependence. Even though that's a recommendation, that's a decision that I make and the staff make basically based on our experience in working with nicotine-dependent patients.

Q. May I see Exhibit 12, please?

A. Uh-huh.

Q. Why don't you do the FTND and nothing else?

A. What do you mean, do the --

Q. In assessing whether somebody is dependent, why don't you just give them the FTND and nothing else? Why do you give all these other ones?

A. I just answered that question. I went through, and the reasons is that we just want to make sure. I think we're being very careful.

I think the FTND is good, but you need to be able to have a series of them. Because just looking at the number of cigarettes, as an example, you don't, because someone is smoking 40 as opposed

to 20, your natural assumption is the one that is smoking 40 is more addicted or is heavily addicted or twice as addicted, the average person would say, than someone smoking 20. But when you put them together and look at them, you may find that, in fact, the one smoking 20 cigarettes may, in fact, be the more highly-dependent person.

More information is not bad. I think we need, when we are treating people, we need to be very accurate in what we administer or what we provide or what we recommend. So it is very important that we be very accurate, and we do all of those tests.

Q. Just tell us, if you could, in your own words, at the Center how you assess, what is the process by which you assess whether someone is dependent? Just start at the beginning and tell us

what you do.
A. Could you give me that back a moment?
Q. Sure. You can have this. If there is anything else you need, just ...
A. No problem.
Typically, again, someone would call in. They are interested in quitting smoking. We

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would invite them in for a variety of tests. And then when they would come in we would talk to them. We would look at, I mean, there's a whole list of questionnaires that we fill out in terms of they have a physical, do a little history and so forth, which the physician participates in.
So we do a whole little battery of tests, both in terms of dependence, in trying to look at dependence, we ask them a whole variety of just basic types of questions about motivation and so forth. We administer the FTND or the FTQ, we look at, and that has the number of cigarettes. We ask them about how many cigarettes they are smoking and so forth. We look at when they smoke, or the critical question within the FTND or FTQ is the first cigarette in the morning.
We look at cotinine levels because we know certain levels, and we have a little scale that we can look at and say, This is typically a high dependence or a low dependence or whatever. We look at that scale. It's the same way with CO levels.
So we do a whole battery of tests and questions in doing the physical and so forth. It

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would probably take us three, four hours, somewhere in that vicinity, to actually administer and take all of this.
Then at that time we make a decision, with the actual patient, what they want to do. In other words, we talk to them, and maybe we decide the gum might be best for this person. But, interestingly enough, this person has dentures. So gum chewing would not be an option for them. So, therefore, we would say, Maybe we will use the patch with you.
Or if someone is talking about their, just in the conversation and based on the judgment of the counselor that is actually working with the individual, they may, in fact, talk about they may be a little more depressed or whatever, we may, in fact, use Zyban.
But a lot of it is just feeling your way through, giving these questions and then discussing it.
Sometimes the counselors will even discuss among themselves, What do you think? We've got counselors that have participated in helping thousands of people quit smoking over the years.

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So that being the case, we make a judgment what we think is recommended or whatever.
Then at that last point, we bring in the physician and discuss with him. Then we go about providing, either providing or recommending

nicotine-replacement therapy as or the Bupropion and then include them in a counseling program, because thereafter, once we go through about four hours with them, three or four hours, they come in for seven, eight weeks thereafter. Every week they come in and we talk about how they are doing and so forth and try to provide encouragement and assist them, whether they are experiencing withdrawal or how the medication is working, things of that nature. So we follow them for about two months.

Then thereafter, after two months, they are allowed, everybody that comes through our program is allowed to come into the program for the next year, you know, for maintenance. Anytime they want to, one day a week, they can come in just to be able to visit and see how they are doing and seeing what's going on to actually provide encouragement.

So that's, in a nutshell, I know

that's a rather lengthy answer, but that's, I can get real specific, but that is in general what we do.

Q. Thank you. If you could, Doctor -- and this is not a criticism in any way -- if you could try and speak a little bit more slowly, especially when you have a long answer, that would be helpful to the person who is taking down the answer.

A. Okay.

Q. That is in no way a criticism.

A. Sure.

Q. You said that you could go into more detail. Let's do that.

The first thing you said is when somebody calls in with an inquiry the first thing you do is invite them in for a personal visit.

A. Correct.

Q. Why do you do that?

A. Because they have called us to, they are smoking and they would like to, in fact, try to quit. And usually they have tried on their own and have not been successful. So they need assistance.

And every now and then we get

referrals from other physicians where patients are -- in fact, we had a couple last week that were experiencing Buerger's Disease, basically a cardiovascular problem, and were having a circulation problem and had lost, I think it was a leg. I think one of the counselors went over there to do a consult. But they had lost a leg or and arm. They had lost a limb, anyway. And the physician felt that it was due to smoking, and they wanted us to go over there and visit with them.

Then we went over there and talked to them and invited them to come in because we felt that they needed to quit.

So some people will call us. Obviously, if they're calling us and want assistance, we invite them in.

And occasionally we'll get a referral for people that are, for a variety of reasons, due

to smoking, are close to death. And they are invited in so that, or we are invited over to visit with them in hopes of trying to get them to quit smoking.

Q. Thank you. If you could talk just a little bit more slowly, it would be very helpful.

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A. Okay.

Q. I appreciate that answer. What I intended to ask you was why is it that you invite them in for a personal evaluation instead of, for example, doing the evaluation over the phone or through the mail?

A. Okay. That's, I mean, my first response, I think, was appropriate for your question, but you are talking as opposed to the phone.

We actually want to get the person in to do a CO level, to actually blow through things. We may have to do a blood draw and things of that nature. So it is very difficult to do that over the phone.

Q. For the process of assessing whether a purpose is dependent, why don't you just do it by the mail or do it by fax or something like that?

A. Again, that's only a small part of what we do.

Q. I'm asking you about that part, though.

MR. GOLDBERG: I'm sorry. Objection. Which part are you asking?

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MR. ROWLEY: There seems to be confusion about the question. Let me clarify it.

Q. In the process that you described in your long answer before, you said that you invite people in for face-to-face interaction. Why do you do that instead of doing it, for example, by phone or by fax or by mail? That's the question.

A. Again, because the battery of tests that we are doing, it is very important that we try to determine, talk to the individual, because we want to see about their motivation. We want to see a whole variety of things about the levels of addiction and so forth. And we do some tests and things that is very important, like blood draws and so forth. We simply can't do that or get CO levels.

Plus, we always encourage people to come in because we want to visit with them face-to-face.

We find when they come in that shows a little more, I mean, there is a little more involvement. A lot of people want to quit, but they want you to do the work for them. In other words, the bottom line is, in fact, if you are, I

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mean, they need to be motivated themselves.

The medication, unfortunately, that we have doesn't do it in and of themselves. They need to be a little motivated. The medications that have been developed and so forth, basically, assist them with withdrawal and craving and so forth; and

it makes it a lot easier for them to quit. That's why they have been so successful. But the medication in and of itself does it for many people. But when you add counseling and getting involved, you can usually double those success rates.

Q. Can you tell us whether in assessing whether a person is dependent on nicotine, whether it is important for the counselor, whoever it is who visits with them, to be able to assess, face-to-face, through interpersonal interaction with the person, that person's motivation?

A. I think we actually ask them. In other words, again, we do this whole battery of tests.

You keep singling in on one thing and how this or that could, in fact, be. The bottom line, it's a battery of tests. It's the feel that

these people have in just talking to them. Someone will come in and say, Hey, I don't, you know, I don't think this person may, in fact, be a good candidate, or a bad candidate, or whatever. In other words, a lot of it is feel.

We look at these tests and we discuss with them what, in fact, is possible. So it's very important.

You are talking about people that have been trained and educated to administer these tests. And they are using their professional judgment in working with these individuals.

Q. Is observing the person's demeanor, that is, the patient's demeanor and their body language and how they respond to questions, and things like visual cues, important in making the assessment of dependence?

A. I think that's really hypothetical. I think when you are talking to anyone you always observe what they doing. But we really rely on the tests and so forth.

We want that person person-to-person so we can, in fact, do the COs and the blood levels and look at those type of things. But anytime

anyone comes in you don't put on blinders. You always observe them and see what their reactions are, whatever. But that's not how we determine if a person is addicted or not addicted. That's just not the way we do it.

Q. Let me ask you this: The process of diagnosing dependence involves the concept of differential diagnosis, like all other diagnosis; is that true?

A. What we do, again, what we go at, and these are the tests that we use to . . . I can't tell you about other addictions or whatever. My 25 years of experience is working primarily with nicotine addiction.

And these are, in fact, the tests that we use to determine whether a person, number one, is addicted, or whether that person is, in fact, high or low addicted, so we can prescribe or recommend appropriate treatment.

Q. My question -- Let me move to strike that.
My question, Doctor, is, is the part of diagnosing nicotine dependence -- Let me rephrase.

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Is the process of differential diagnosis a part of the process of diagnosing nicotine dependence?
A. What do you mean by "differential diagnosis"?
Q. Do you know what the phrase --
A. I want --
Q. Excuse me. Do you know what the phrase, without me defining it for you, do you know what the phrase "differential diagnosis" means?
A. I would like, actually, your operational definition of what it is so I can respond to your question.
MR. ROWLEY: Please read my last question back.
REPORTER: "Is the process of differential diagnosis a part of the process of diagnosing nicotine dependence?"
A. Again, what we do is these are the questionnaires that we, in fact, use to be able to diagnose whether the person is, in fact, nicotine-dependent or whatever. I don't know about other dependence or whatever.
We primarily, our years of experience

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have been spent on using tobacco. As far as differential or whatever or using any of the other terms for the others, I don't know if they are used there or whatever. But we specifically have been trained to use these questionnaires to be able to determine the level of addiction.
Q. What does the phrase "differential diagnosis" mean, Doctor?
A. I don't know what else to tell you. But these are the questionnaires that we use for diagnosis. Whether I know that term or don't know that term is really irrelevant on what we do.
I think your question is really designed to say that I don't know something or whatever. But that's not, that's not the case.
We work with nicotine-dependent patients. You keep bringing a lot of extraneous types of things into the discussion, which makes it very frustrating.
Q. Doctor, do you know the definition of differential diagnosis?
A. I think I have answered that.
Q. Doctor, what is the definition of differential diagnosis?

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A. I think I have answered that.
Q. Doctor, I didn't hear the definition. Would you mind repeating the definition for us?
MR. GOLDBERG: Asked and answered.
MR. ROWLEY: Counsel, if that was asked and answered, perhaps you would be kind enough to repeat for us the definition of

differential diagnosis that the witness gave.
MR. GOLDBERG: The witness gave an answer that explained his method for diagnosis.
MR. ROWLEY: I didn't ask him about his method for diagnosis. I asked him for the definition of differential diagnosis.
MR. GOLDBERG: That was what his answer was to your question. You may not --
MR. ROWLEY: It wasn't responsive.
MR. GOLDBERG: Pardon me?
MR. ROWLEY: It was not responsive.
MR. GOLDBERG: You may not like his answer. You may disagree with his answer, but he has answered your question based on his knowledge.
MR. ROWLEY: Let the record reflect that counsel is unable to repeat the doctor's --
MR. GOLDBERG: Do you want me to

repeat the whole answer?
MR. GOLDBERG: No. I want to know what -- Let me ask the question again.
MR. GOLDBERG: I'd be glad to repeat it if you want it.
Q. Doctor, what is the definition of differential diagnosis?
MR. GOLDBERG: Objection. Asked and answered.
Q. Please either give me a definition or tell me that you don't know the definition.
A. You asked me initially the question with differential diagnosis in there, and then you have now changed the questions. If you could give me an operational definition of what differential diagnosis is, then maybe I could provide you, tell you that.
It is really simple. I have answered it to the best of my knowledge, to the best of my ability. If you don't like the answer, that's fine. But that's, unfortunately, I guess for me or you, that's the answer that I have.
Q. What is the definition of differential diagnosis?

A. I believe I have answered that.
MR. GOLDBERG: Same objection.
Q. What is the definition of differential diagnosis?
A. I believe I have answered that.
Q. What is the definition of differential diagnosis?
MR. GOLDBERG: Same objection.
A. I believe I have answered that.
MR. ROWLEY: I think we are at a point where we may need to contact the Court. Let's go off the record and let's confer.
(Off the record.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Doctor, have you ever seen the phrase "differential diagnosis"?
A. Yes. I have seen the phrase.
Q. Have you ever seen the phrase defined?

A. Probably never actually defined.
Q. Do you have an understanding of what the phrase "differential diagnosis" means?
A. That has nothing really to do with

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what we do. We have been trained in diagnosing nicotine dependence, and that's what we do. That, in fact, may be differential diagnosis or whatever. I have no idea. What I do and what we do and what our people are trained is to work specifically with nicotine and not other addictions. And that's basically how we're trained, and that's what we do.
MR. GOETZ: I want to move to strike that statement as non-responsive. And just note for the record on behalf of Reynolds that the witness is not answering the question. It's a simple question.
On behalf of my client, Doctor, I would appreciate it if you would just answer the question. It would help us get out of here a lot sooner. I think it's a simple question. On behalf of my client, I would appreciate it if you would just answer the question that's asked.
MR. GOLDBERG: I move to strike your comments. The witness has been answering the questions. The witness has been direct with his answers.
MR. GOETZ: Direct with his answers? I can't imagine a more simple question than, What

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is your definition of differential diagnosis? Do you know what the term is?
MR. GOLDBERG: The witness answered the question.
MR. ROWLEY: What was the definition he gave, Counselor?
MR. GOLDBERG: He gave the answer that the term "differential diagnosis" is not used by him in his work and that his focus is on assessing whether there is tobacco or nicotine addiction and not assessing whether there is other addictions. That's my understanding. But the answer is in the record, and it speaks for itself.
MR. GOETZ: I think the question was, Do you know, Doctor, what the term "differential diagnosis" means?
MR. GOLDBERG: We are not going to two-team him. We're going to go one at a time.
MR. GOETZ: I'm entitled to express my objections, am I not?
MR. GOLDBERG: If you are going to make these long objections, I'll will make my long objection to your objection.
MR. ROWLEY: Let's proceed.

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BY MR. ROWLEY:
Q. Doctor, regardless of whether you use the term "differential diagnosis" in your work, setting that question aside, forgetting that issue for a moment, not considering whether you use the term in your work, forgetting about that, set it aside, do you have an understanding of what the phrase "differential diagnosis" means, yes or no?

A. I think that's beyond my expertise in the sense that that's probably a secondary expertise. I told you before that I'm not a psychologist. I'm not a psychiatrist or whatever. So those are people that do those types of things. I typically don't get involved there.

What we do, again, all we are doing is determining addiction relative to the things that we do and work specifically addiction. If you want, wish to call that differential, I mean, that's perfectly fine with me. But what we do is very specific. You're just bringing in outside information that really doesn't have anything to do with what we do.

Q. Let's see if we can just wrap this up. And if you can simply answer this question I will

move on to a different question.

You do not, as you sit here, have an understanding of the definition of differential diagnosis that you can describe for us in words? Is that true?

A. I have never seen the word actually defined.

Q. Since you have never seen the word actually defined, am I correct in inferring that you cannot give us a definition?

A. I have never seen the word defined, and I cannot give you that definition.

Q. Thank you.

In diagnosing patients with respect to the issue of whether they are nicotine-dependent, do you engage in the process known as differential diagnosis?

A. That one I answered once before. If you go back and look at the record, that was, I believe, one of the very first questions that you asked, and I have already responded to that.

Q. Doctor, in diagnosing whether a patient is nicotine-dependent, do you rule out other conditions? Is that part of the process?

A. What conditions are you referring to?

Q. Any other conditions. Are any other conditions ruled out as a part of the process of diagnosing nicotine dependence?

A. I guess I'm not sure what you want there. If you could -- What other conditions, I'm not clear on that. If you could really share what conditions, I could hopefully tell you yes or no.

Q. Let me ask you a different question.

Is there any condition that you can name for us today that you attempt to rule out as a matter of course when reaching a diagnosis of nicotine dependence?

A. The word "condition" is just incredibly broad. If you could be specific, I think I could hopefully answer a little bit better. But I'm not, I don't know what you mean "condition." I have no idea what you are talking about.

Q. By "condition" I mean any disease, psychological or psychiatric condition that is

different from nicotine dependence.
A. Yes. Some of those.
Q. What diseases or conditions do you

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rule out or attempt to rule out as a part of the process of assessing whether an individual is nicotine-dependent or addicted?
A. That's not nicotine-dependent or whatever, we don't -- I probably need to back up a little bit and tell you that that's -- I probably misunderstood your question, or maybe you just said it differently. Your questions sometimes are a little long. What I'm referring to is we don't use any of that to determine whether a person is addicted or not addicted. That's not simply what we look at. We don't rely on any of those conditions. If someone has cancer or someone has emphysema, we don't determine, use that as something to rule out, because they have a special condition.
I guess what I was thinking about -- and remember, we do two different things at the treatment center. Basically, we conduct clinical trials. And then the other is we actually do the research. And in the clinical trials there's certain protocol that's been agreed by the FDA that people are excluded. But that's just to be in the study.

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MR. ROWLEY: I move to strike the answer as being utterly unrelated in any way to any aspect of my question.
MR. GOLDBERG: Move to strike your comment.
MR. ROWLEY: You are moving to strike objections?
MR. GOLDBERG: Yes. Speaking comments.
MR. ROWLEY: You are moving to strike motions to strike. Unbelievable.
BY MR. ROWLEY:
Q. Doctor, are there medical conditions that can cause what you call withdrawal symptoms that you believe are associated with nicotine cessation?
A. Medical conditions, like what types of, can you be specific?
Q. If I were to tell you that I would be answering the question for you, Doctor; and I'm not here to answer my own questions. I'm here to ask you questions. So let me restate the question. And I would appreciate it if you would either answer it or say you don't know.

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Are there medical conditions that can cause the manifestations of withdrawal that you believe are associated with nicotine cessation?
A. Again, we don't screen out for that in particular. We don't look at -- Again, you are pulling out one thing again, and you are talking about withdrawal. We do a whole battery of tests to determine whether that person is addicted and what level they are addicted to. You are pulling

out one questionnaire, possibly one little piece of withdrawal symptoms, and trying to match that up if we eliminate the condition. It's not one piece that we look at. That's what makes our program so good, is we have a whole variety of the things that we look at. That is but one small piece. That isn't the big picture.

Q. So you're saying that you can't assess whether somebody is dependent just by looking at whether they have withdrawal symptoms? Is that what you're saying?

A. We use a whole battery of tests. We can make assumptions, and we can look and say maybe that person is experiencing. But we don't go in and do a one-shot or a one-scale or just very

quickly make a determination just by asking or observing. That's not what we do. We provide a --

Q. You --

A. If I could finish.

Q. I apologize.

A. We can provide -- We do a battery of tests to make that determination. You are trying to make it seem like we just use one thing and we see them experiencing withdrawal and then they are addicted. That is just simply not true. We do a battery of tests.

Q. It's not a short, simple process, is what you are saying, I guess? I'm just trying to understand what you're saying.

A. Yes. A process to determine the level or addiction?

Q. Yes.

A. Yeah. It's not, we don't take it lightly. We get involved and we do a battery of tests to make that determination. We don't use just one, use number of cigarettes.

Q. Doctor, are there medical conditions -- I understand what you just said -- and subject to what you just said, are there medical conditions

that can cause the manifestations of withdrawal that you believe are associated with nicotine cessation?

A. Sorry. Could you repeat that again? I was coughing.

MR. ROWLEY: Would you mind reading it back? I'm sorry.

REPORTER: "... Are there medical conditions that can cause the manifestations of withdrawal that you believe are associated with nicotine cessation?"

A. Typically what we do, in explaining the process to you again, I don't, we don't look at the medical conditions. That's not what I do. We do the evaluation, and we do put, go through the battery of tests. We have two physicians on staff that, in fact, this information is provided to them. They look at it. And they look at the medical conditions and they make those determinations. I think we made it clear that I'm not a physician, so I simply don't do that. I don't.

Q. Is it correct that you don't rule out, in assessing a patient for nicotine dependence, you

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don't rule out medical conditions that might be a cause of their withdrawal symptoms?

MR. GOLDBERG: Object to form.

Q. Is that true or not?

A. Again, we don't, you know, we don't eliminate anyone on any one thing or any condition. What we do is we do the battery of tests and make the determination based on several items and several questionnaires, not just one.

Q. Is there anything in your battery of tests that's intended to rule out medical conditions that might be the true cause of the patient's withdrawal symptoms?

MR. GOLDBERG: Objection to form.

A. I don't know what you mean by "true cause of withdrawal symptoms."

Q. That might be the actual thing that is causing the symptoms that you interpret as withdrawal symptoms.

A. No, when you look at cotinine levels and nicotine levels that are a certain level, and the number of cigarettes or whatever, we make a determination on how addictive the level of addiction that person is.

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Then that information is provided to the physician who, in fact, takes a look at the medical history, the medical record, looks at all the tests and makes that determination.

Q. What are the symptoms of withdrawal that you assess there at the Center as a part of determining whether somebody is nicotine-dependent?

A. I have actually submitted those. They are in one of the reports.

Q. One of them is a dysphoric or depressed mood?

A. Can I take that?

Q. Absolutely. You may look --

A. Which one is it?

Q. You may look at anything that you would like to look at.

Doctor, let's not waste time on this. I think you cited the DSM for the symptoms of withdrawal. So I will just show you the DSM.

Tell us, what are the symptoms of nicotine withdrawal? They are right there in that box.

A. Yeah. I'm just taking a look, making sure, looking at the appropriate ones.

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Dysphoric or depressed mood, insomnia, irritability, frustration, anger, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite or weight-gain.

Q. May I see that, please?

A. Uh-huh.

Q. I know it is only a part of the information that you use in assessing whether an individual is dependent or addicted, but looking at and asking them about these withdrawal symptoms is

a part of that process; is that right?
A. We don't specifically ask every one of those. Again, we don't go and -- You're using one tool and applying it as completely. We have a whole battery of tools and things that we use. So that is just one of them. You're trying to take that we don't apply and say, Did you experience anxiety? Did you experience --
Q. I understand.
A. A lot of it is in the dialogue that we are talking about there. And they bring them up, because we find that when you bring it up to them they are almost always experiencing it. We do it in the course of the conversation, and then we

record these.
Q. I understand what you're saying. What you're saying is the process that you go through is intended to elicit this information.
A. Yes. To a certain degree, yes.
Q. That involves this face-to-face interview process, which has as one of its purposes to elicit information on withdrawal symptoms. Maybe not ask about every single, specific, conceivable, possible withdrawal symptom, but to elicit information from the patient regarding these withdrawal symptoms. Is that fair?
A. Not necessarily to elicit, because we try not to put words in their mouth. Basically, when they come in, if someone has made a previous attempt at quitting smoking, and we will say, Well, what happened, Why did you go back, or, What did you experience? Invariably, they will start naming some of those. Then once they begin to name those, then we begin to see that that's just one little small piece, and say, Yeah, it appears they are experiencing withdrawal. Yes, they appear that they have this high score or FTND.
So it starts a whole, it's a whole

bunch of pieces of the puzzle that we put together. Again, it's not something that we take lightly and we don't use one thing, if they experience anxiety or lack of concentration we determine, yes, they are addicted. It's just not that simple.
Q. I see. Thank you.
Whether a particular person is dysphoric or has a depressed mood depends on the person you ask?
A. Yes.
Q. Whether the person has insomnia depends on the individual who is there seeking treatment?
A. Yes.
Q. Whether the patient is irritable depends on which patient you ask?
A. Correct.
Q. Whether the person is frustrated depends on which person you ask?
A. Correct.
Q. Whether the person experiences anger as a part of withdrawal depends on the person you ask?

A. Correct.

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Q. Whether the person is anxious depends on the person you ask?
A. Correct.
Q. Whether the person has difficulty concentrating depends on the person you ask?
A. Correct.
Q. Whether the person has restlessness as a symptom of withdrawal depends on the person that you ask?
A. Correct.
Q. Whether the person has decreased heart rate as a symptom of withdrawal depends on the person that you ask?
A. Correct.
Q. Whether the person has increased appetite as a symptom of withdrawal depends upon the person that you ask?
A. Correct.
Q. Whether the person has weight gain depends upon the person that you ask?
A. Correct.
Q. One person may indicate that he has one or more of these symptoms, while other people may indicate that they have different, a different

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set or grouping or mix of these symptoms?
A. That's correct.
Q. That's why you ask the questions, to find out who has what?
A. Yes. Again, it's not in a Q and A format. Basically, it's just a discussion and we collect this information. Again, it's just a small piece of how we determine whether the person is addicted --
Q. Okay. You say --
A. -- or the level.
Q. I'm sorry. Are you done?
A. Yes.
Q. You say it's a discussion because it involves give and take between the person conducting the interview and the patient; is that right?
A. Yes.
Q. The question that the interviewer will ask next may depend upon the last answer that the patient gave?
A. We don't, again, we don't ask the questions. This is information that they elicit. We have found, that if we ask questions we put

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words in their mouth. Because if they don't share it with us, if they're experiencing anxiety or lack of sleep, if we ask them, and I'm sure if I ask you, Have you been experiencing anxiety or something, anyone, people invariably, if you ask them two or three times, they almost always say yes. So we try not to put words in their mouth.
It's in the course of discussion that they bring it up. And typically it comes up when we say, Have you tried to quit before? Most smokers have. You say, How was it? What did you

experience? What was happening? And it's at that point that they will share with us.

We can usually make a determination on that little tenth of a piece in relationship to all of these other things that we do that we make that determination. It's not on whether they just experience restlessness or lack of concentration or dysphoria or anything.

Q. I see. So give me an example of the kind of, give me an example of how during this discussion -- I realize that there are other ways that you try and elicit this information as well, through, for example, these batteries of tests --

but in the discussion part of the assessment, which I understand is only a part of the necessary assessment, but during the discussion part, how do you get the information from the patient regarding his or her withdrawal symptoms, if any? How does that happen?

A. Sure. I think I have answered that before, and several times. Basically, we will just say -- and I think it is the way I finished the last question -- We are sitting here, you are a smoker, and I will say, Have you ever tried to quit smoking before? And you'll say, Yes. Well, what happened? Why did you relapse, or, What were you experiencing, or, Was it difficult? Just different counselors handle it different kinds of ways.

Q. I see.

A. What you're trying to do is sort of non-directly get them to speak and talk to you so you can begin to record some of these. So it's non-directive. We're not directing them anywhere.

Q. I see. You're not leading them?

A. No.

Q. You want their perception of their own individual circumstances; you don't want to put

words in their mouth?

A. Correct.

Q. Because if you did that you might taint what they are saying or you might steer them in a direction that isn't helpful in terms of assessing whether they're dependent.

A. Yeah, possibly. I mean, I am sure there may be a counselor that that in probing a little bit further, because someone will say, Well, I had a little restlessness. And they'll say, You're referring specifically to sleep? In other words, they may do a little more probing. So, in fact, they may ask something like that.

But it's not something that we get the DSM-IV criteria out and say, Tick these off. Did you experience this, or whatever? Because invariably, in my opinion and professional judgment, sometimes people will, I won't say overreact, but if you ask them -- we learned this very early, that when we would ask questions and ask them several times, they begin to experience some of those. And it's better that it be non-directed.

Q. I see. But there is some probing

involved, at least some followup conversation to the patient's initial comments?
A. Correct.
Q. And the followup conversation is often based upon the patient's initial comments?
A. Correct.
Q. That's the probing -- I don't want to dwell on that word too much, or make it sound more significant than it is -- but that's the probing aspect that you're --
A. Correct. Again, there are two little differences here in the sense that we do clinical trials, and that is in those clinical trials people have a diary where they, in fact, do possibly check or look at what they may have experienced on the medication. But in the actual treatment service that we provide, that's not typically the way that we do that.
Q. In the process of assessing who's nicotine-dependent, the amount of probing and the type of probing, obviously, differs from patient to patient? It depends on their initial comments?
A. You are talking about the counselor's probing?

Q. Yes.
A. Yes, I would say that there's a little direction or a little initiative that the counselor has to take, and that comes from the training and their skills and their ability to be able to ask this question or just discussing with them or just talking with them.
Q. In other words, the followup questions that are asked or the direction of the discussion that is a part of the assessment of whether somebody is nicotine-dependent depends on, in part, it may depend on many things, but it depends in part on the patient's initial comments during the discussion?
A. Yes. Their comments, yes. Because we have to, the number of cigarettes, we have to take them at face value that they are smoking what they tell us, that they smoking, and just a variety of things that we ask them. We do look at the total record. And a lot of that is a non-directive interaction that occurs between the counselor and the smoker.
Q. You say you look at the entire record. You mentioned that the person is given a physical.

Do you look at the results of the physical?
A. Uh-huh.
MR. GOLDBERG: You have to say yes.
A. Yes. I'm sorry. Yeah, they are given a physical as well.
Q. A medical history is taken?
A. Yes.
Q. Do you look at the medical history as a part of assessing whether they are nicotine-dependent?
A. Not the medical history as much. If someone is experiencing, say has emphysema or some

of those types of things, that's just something that we are aware of, and that usually designates that they've been taking in an incomplete combustion or something.

But overall the physician looks at that, and all the data that have been collected relative to the diagnosis of the dependence, and the physician looks at those and a determination is, in fact, made.

But we don't make medical decisions.

Q. That's not what I intended to ask. Part of the medical history may, in fact, contain

information about how the patient felt when he attempted to quit. It may contain information about whether he was anxious when he attempted to quit.

A. Yes. That's correct.

Q. And that information -- I'm sorry. Were you done?

A. No. I think that's correct. That data is collected. I'm sorry.

Q. And that information could be, and I think I hear you saying that it should be used as a part of guiding this discussion with the patient?

A. Yes.

Q. Obviously, the medical history of each patient, and I don't mean what diseases they have, I mean the complete medical history of the patient, including their symptoms, differs for every patient. It's different for every patient; correct?

A. Yeah. There are some that are similar. But on the whole they would, there are subtle differences, little degrees, a little bit this way or that way. So there are subtle differences. There isn't an exact blueprint of

every smoker, if that's what you are asking.

Q. That's because every smoker has a different smoking history?

A. Yes. They have different smoking histories and so forth.

But once you go through this battery of tests, what comes out the other end is whether they are addicted or not.

Q. Right.

A. And even though there's a lot of little subtle differences, we make a, determine, number one, whether they're addicted or not, and then, two, whether they're high or low dependence addicted.

Q. Basically, you decide whether they're dependent or addicted based on all the information?

A. Yes.

Q. It wouldn't be appropriate to look at just a piece of it?

A. No, I don't believe so. Well, I know it wouldn't.

Q. It wouldn't be appropriate to look at just one test battery?

A. No.
Q. It wouldn't be appropriate to look at just the interview?
A. No.
Q. It wouldn't be appropriate to look at just the physical examination?
A. No.
Q. It wouldn't be appropriate to look just at the medical history?
A. No. It would not.
Q. It wouldn't be appropriate to look just at the CO levels?
A. No. It would not.
Q. It wouldn't be appropriate to look just at the cotinine levels?
A. No. It would not.
Q. It wouldn't be appropriate to look only at the number of cigarettes smoked?
A. No. It would not be -- if I could just finish this one.
Q. Yes. Please.
A. And a lot of people, in fact, do, like physicians, just a general practitioner out there, sometimes they don't have the level of information

and knowledge in working with these individuals. And they may, physicians may, they don't do nicotine, cotinine, and they don't do COs and so forth, typically, because it's an expense. Many of them look at just the number of cigarettes. They may use the FTND.

I think that's what makes our program unique and so successful, is that we have a whole battery of tests that we bring to bear, and just don't use one of those, because it can be misleading as well. Something may be, one of those may be misleading, and that's why we have a whole battery, to kind of counter-balance one that may be a little misleading.

Q. Got you. Understood.

So you use the physician's input as part of the assessment? For example, the physical exam.

A. Yes, exactly.
Q. You don't look at just the physician's input?
A. No.
Q. That wouldn't be appropriate?
A. No. Unless the physician were doing

all of these tests. And there are some that, in fact, will do that as well. In other words, many physicians are very involved in the process, and they would do that. At our Center we have psychologists, health educators, social workers and nurses doing that.

Q. What you are saying is it would be appropriate to look at what the physician did if he did all of these things that you are describing?
A. Say that again.
Q. It would be appropriate to look only at what the physician did if he did all of these things that you are describing?

A. Yes.
Q. How long does the physical exam take, typically?
A. Thirty minutes probably. I'm just guessing. Almost 30, 45 minutes, somewhere in that vicinity. Then, if any problem is discovered or whatever, there may be some probing.
Since we, at our place we are a teaching institution, medical school, we work with students a great deal. A lot of the students will assist the physicians with physicals, because they

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are learning about probing and asking questions.
So I'm not quite sure what it would take in a regular office. But it can take anywhere from 30 minutes. Probably be safer to say an hour, because some people you have to go back in there and visit because you uncover other problems, some that are tobacco-related. But you uncover a lot of other problems that are, in fact, non-tobacco related that you need to refer or send someone on.
Q. I see. So what problem a particular individual has can affect how long the physical examination takes?
A. In general. I think you can generalize it to a certain degree. But, yes, I think that is fairly accurate.
Q. One person's physical examination may take a comparatively short time, and another person's may take a comparatively long time, is what you're saying?
A. Yeah. I think when you say long and short, if you could just give me a number and then I could, because I don't know, short to you may mean a minute or short to me may mean 45 minutes.
Q. One person's physical exam may take 30

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minutes; another person's may take an hour?
A. Yeah, I think that is, probably 30 minutes to an hour. I'm giving you a range, and that's very typical.
Q. Another person's may take more than an hour? That happens?
A. Yes, it could.
Q. Depends on whether, for example, diagnostic studies are indicated as part of the physical exam?
A. Yeah. The physician makes all of those determinations if he finds something and does a little more. Because we try to be conscientious there in the sense that if we find something that's unrelated we'll refer it to someone else. They'll still go in and talk and say, We discovered or uncovered this, and so forth.
Q. In a diagnostic study itself, depending on what it is and what is indicated, can itself take a half hour or an hour or two hours, right, depending on the diagnostic study that is required? Right?
A. Again, that's, I mean, it could take that long. But that something that the physician

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does.

Q. Sure.
A. I don't do that.
Q. Yeah. And I don't mean to imply that you are the person that makes that decision.
A. I just want to make it clear.
Q. No, I understand. But you are familiar with the process, and you know how the process works. You are the director of the center; right?
A. Correct.
Q. Therefore, you know that if a person is referred, for example, to a specialist, that may involve another 30 minutes of evaluation? Is that true or not? I don't know.
A. Yeah.
Q. Is it?
A. I don't know. Once we uncover, say we uncover a medical condition or the physician does, then he refers him to someone else. I have no idea how long they, in fact, may be at the other place. So I don't any idea, because that is not something that I query or ask about. We just try to act responsible and refer the person to the appropriate

physician or center if we, in fact, find something wrong.
Q. So if a particular individual has major depression, and that's revealed during the physical examination -- major depression is a psychiatric condition, is it not?
A. Yes, I believe it is.
Q. If that person has major depression, the diagnosis of that condition as a part of this process may require referral to a psychiatrist, for example?
A. Sure.
Q. And that assessment may take additional time as a part of this process?
A. Yes. That's not typically what we do in the sense that --
Q. I understand.
A. -- we are very fortunate in the sense that our two physicians, one of them is a psychiatrist and board certified in internal medicine as well. So it usually goes beyond -- and he is also the director of the alcohol treatment facility over there. So he looks at individuals for a variety of things, and he recommends them.

And probably they may, in fact, go back to the psychiatric hospital. He has skills and tools because he is trained, board certified in two specialties. And his wife is also a psychiatrist. They both work on the research and in the clinical trials with us.
Q. Do a lot of people at the Center have spouses who also work at the Center?
A. At the actual Tobacco Center?
Q. People affiliated with the Tobacco Center.
A. Yeah. I think they are the, they work together. She fills in for him when he is gone. Then my wife and I, I believe, are the only -- I'm

trying to think -- No, there is no one else.
Q. Your wife earns her salary from working at the Center?
A. No. Hers is soft money, which is grant money.
Q. Your wife's income is soft money?
A. Yes.
Q. Is the psychiatrist's wife's money soft money?
A. No. Both of them are positions, and

they both are paid by the University. I'm paid by the University, and the two physicians are paid by the University. And my wife is basically on grant money.
Q. Is any of this soft money that your wife gets -- Let me rephrase.
Does any of this soft money that your wife gets come from pharmaceutical companies, directly or indirectly?
A. Yes.
Q. How much money has she been paid in soft money from pharmaceutical companies that make money selling smoking-cessation devices?
A. Are you talking salary? Is that what you're asking?
Q. No. How much money has -- is it Mrs. Glover?
A. Yeah.
Q. How much money has Mrs. Glover been paid by pharmaceutical companies that sell smoking-cessation devices?
A. She gets paid a salary. That's what she gets paid.
Q. So you can answer that question by

telling me what her salary is?
A. Yes.
Q. What is salary?
A. Sure. She makes about, I think she just got a raise because she got a promotion just this year. She was making like $36,000 last year, and I think beginning July 1st she got promoted to research assistant professor. And she is making, I think, 46. I can't really tell you. I think she got like a $10,000 raise or something like that. That's her salary.
Q. Is every penny of that soft money?
A. Yes.
I guess the soft money, for people that don't know, soft money is basically grant money. In this case it would be the pharmaceutical companies.
Q. I understand.
Did you play any role, any role in her receiving that increase in the amount of soft money from pharmaceutical companies that she is paid?
A. The pharmaceutical company -- I need to make this very clear -- you just sort of implied, or at least I interpreted that question

that the pharmaceutical company pays her, and that is just simply not the way --

Q. I didn't mean to imply that. I will withdraw the question. I didn't mean to imply that.

My question is, you said she just got a raise, did you play any part in the decision or the process of the decision that resulted in her raise?

A. No. Basically, what happens is she's responsible -- because there was concern because of nepotism and so forth, and she is responsible to the director of the cancer center, and she is assigned to our unit, because she is over in Behavioral Medicine and Psychiatry.

So she is assigned to that unit. So even though she runs the Center and I'm the director, her immediate supervisor is the director of the cancer center.

Just like the two physicians that come over, even though they assist us and work with us, really, their salaries are paid completely by the University. The pharmaceutical companies do not provide them funds or money. They are not paid.

They come over and assist and work with us because we provide a service. And they are incredibly helpful.

MR. ROWLEY: Let me move to strike that as non-responsive.

Q. Did you --

A. I thought that I --

Q. Don't argue with me, Doctor.

MR. ROWLEY: Move to strike that as non-responsive. There is no question pending, Counsel.

MR. GOLDBERG: I move to strike your comment.

Q. Just tell me, did you play any role in the decision to get her a raise? That's all I want to know.

A. Okay. It's very simple. No, I did not. I did not have --

Q. Thank you.

A. Let me finish my question. You know, I did not play a role, because she is not responsible to me. So I would not play a role in that.

And I think for you to cut me off or

tell me to be quiet, I think, is highly inappropriate.

Q. Thank you for answering the question, Doctor.

Some individuals have a lengthy medical history, and other people have a brief medical history. That is true?

A. Correct.

Q. Some people's medical records are --

A. Excuse me.

Q. Some patients' medical records are an eighty of an inch thick and other patients' medical records are five inches thick. Is that true?

A. That may be true. But we, typically, don't go over and recall all of that medical

record. That's not what we do. I'm sure that they have it. I don't know.

In our center people don't have an inch and five inches. That is just simply not the way that it works.

Typically, what we do is we probe and ask the questions or talk to the patient about any problems they may have had. It's literally an up-to-date physical.

We don't go back and look at the, actually go through the records in the cases and all of that and ask the other physicians to send us all of the information. That's not something typically that we do. Only in an unusual circumstance or something would that happen.

So the records don't differ quite as dramatically. They are all pretty much the same size.

Q. So you're saying it is only an unusual circumstance where you will actually go and compile the individual's records?

A. Correct.

Q. Therefore, the question of whether you will go and compile the individual's records depends on who the individual is and his circumstances and the various reasons that you would do that?

A. Yes.

Q. That's something that varies from individual to individual?

A. Yes. But the variability isn't quite as dramatic as you might explain. There is some variability. But that's, in my opinion or

experience, I'm trying to recall, that is probably rare, because we do a complete medical history to date, because, also, since we are a teaching university, they are training the physicians, the young physicians, the new M.D.'s on how to ask questions and so forth.

Q. But the question of whether to get the records depends on who the patient is. That's all I'm saying.

A. Yes.

Q. You say you do a complete medical history to date. How long that history turns out being depends upon the individualized medical history of the particular patient?

A. Yes. That is probably true.

Q. Some people have a long medical history with a lot of hospitalizations and treatments, and maybe counseling or psychiatric care. Other people have a very brief medical history with very few illnesses or hospitalizations and no psychiatric care. Is that right?

A. That's true.

Q. So the length of that medical history when it is written down and the amount of time it

takes to get it, and, in fact, its importance in this assessment varies from person to person?

A. That's correct.

Q. Obviously, the strength of each person's motivation to stop smoking varies from person to person; right?
A. Uh-huh.
Q. Some people are strongly motivated; some people are weakly motivated; right?
A. That's true. Some are a little more motivated than others, yes.
Q. Part of this process of conversing with the patient is to assess the strength of the motivation. That's part of it. I don't mean to imply that you can base the decision of whether they are dependent solely on that. But that's part of the process; right?
A. Correct.
Q. And some patients are more forthcoming in their description of their attributes and their attitudes than other patients?
A. I think that's correct, yes.
Q. It's more difficult to elicit information from some patients than other patients?

A. I think that is true in virtually anything. Some people are just more talkative than others. And some will share, openly share. Some will share a lot of information that's totally irrelevant. They'll go on. So we have to usually try to keep them on track because we want to try to get them out within a reasonable time.
Q. Some patients are reticent and tight-lipped and maybe even suspicious. They're not comfortable with the process at the beginning, and you need to make them comfortable.
A. Yeah. I'm sure anytime anyone goes into a medical setting, kind of like where our center is, I think people naturally get a little nervous. Not everyone feels very comfortable with hospitals.
I do know that we can, some people when they first come in sometimes their blood pressures might be higher than normal, because they're a little nervous. So we just tell them to calm down and relax. They'll sit there for ten minutes and it's retaken, and it falls back to what is considered a normal range.
Q. You have those patients on the one

hand. There are other patients who are really comfortable and will yak your ears off telling you things that aren't even relevant because they are so talkative?
A. Yeah. There are some people that might do that.
Q. That affects the length of time of the evaluation, or it can; right?
A. Yeah. It could effect it some. Usually what we try to do is, in working with people and training them, how to get them back on track, because we are trying to fill out questionnaires, and if someone begins to ramble we just try to, you know, Next question, Let's move on, and so forth.
Q. But I guess the idea is whether the

person rambles or not or whether they are quiet or not or whether they are highly cooperative or not depends on the individual?
A. Uh-huh.
Q. It varies from individual to individual?
A. Yes. To a certain degree, yeah.
Q. In some cases the history of the

number of cigarettes smoked, for example, given by the patient will be consistent with the diagnostic tests that you give. In other words, the cotinine levels will be entirely consistent with what the patient has said? It happens sometimes?
A. Yeah, it can be consistent. It also cannot be consistent. That's why, again, I think if you were to just use one, I think it might mislead you or whatever, just the number of cigarettes. So what we do, they may or may not be consistent, because, again, what we do is look at the whole battery of tests to make that determination if, in fact, they are addicted. Because one of them, you can be misled by cigarettes, something as simple as the number of cigarettes.
Q. That's why you have to do not just those two things, ask the patient and measure the cotinine levels, but you do all the other stuff, too.
A. Correct.
Q. Some people's cotinine levels are consistent with their verbal history of smoking; others aren't consistent. You have got to figure

out why that is? You try to figure out why that is?
A. Yeah, a little bit. We discuss it and say, Why do you think this is happening, or something.
But, again, we are looking, and if they are smoking high numbers of cigarettes and everything else indicates that they are not, whatever, in fact, may not need assistance. But the only thing we are going to know, until they come in we don't know that.
Q. Right. So a person may come in and say that they are smoking a very large number of cigarettes and their cotinine levels may indicate that the laboratory tests aren't really consistent with that, and that's something that you try and resolve?
A. Yes. To a certain degree.
Q. Or it can go the other way; right?
A. Yes. Typically, though, I need to also make it very clear, is when people have come to us -- this is more typical than what you are describing -- people that come to us, almost, very, very, very few wind up not being addicted.

Part of the problem is they have experienced something on their own or something is happening out there. So they are coming in for assistance.

So that is not typically what is happening there. People that come to us usually, in general, tend to be, they want to quit and they need assistance because they have tried on their own.

Q. I understand. So what you're saying is that the people who come to you who take the initiative and call you or who are referred by physicians are not really a random sample of all smokers, for example, in West Virginia? They're kind of a select group in that they are motivated?

MR. GOLDBERG: There are two questions now.

MR. ROWLEY: You're right. You are correct. That's correct. I will rephrase.

Q. What you're saying is that the people who come to see you may be different somewhat from, for example, a random sample of smokers in West Virginia?

A. That's true.

Just to extend a little bit further, so I can explain that, people tend to be a little more motivated because they have experienced a health problem or something is occurring that they have tried. So they do come in because they are possibly a little more motivated.

But most of the studies will show in the literature that up to 70, and up to 90 percent in some of the surveys, typically, make a decision, or at least they have in self-selected surveys have noted they, in fact, would like to quit, but they haven't really gone out to seek problem, seek assistance or whatever.

Q. Even among those people who are motivated, who take the initiative and call you, you see this variation in the amount of their motivation; some are very highly motivated; others are moderately motivated; others have somewhat less motivation, even among the group of people that call you?

A. Yeah. Typically, yeah, most of the people maybe have been -- not most of the people, many people have been thinking about it or whatever.

But typically people that come to us are eager.

It's the group out there that doesn't think that they are addicted or that does not want to seek help because they are not motivated, because essentially what they have been doing is sort of practicing a little self-deception, Oh, I'm not addicted.

And, actually, in terms of my case -- as you know, I mentioned that I was an ex-smoker -- I would always say, I can quit anytime I want to. It's no problem. I can quit anytime I want to. Then when I was put in a position where I had to, I found out that it wasn't. I would always say personally, I'm using an N of one here, but I see that happen often, that sometimes individuals may not think they are addicted when in reality, when

they really try to quit, they are really surprised how difficult it was.
Q. I understand.
A. So you have that little group, too, there.
Q. So you have a little group or some group that believes it's not addictive? That's

what you described; is that right?
A. Yes.
Q. Whether an individual believes he is addicted or not addicted depends on the individual? Some smokers think they are addicted and other smokers think they are not addicted?
A. Yeah. I think the overwhelming is definitely on one side, because of what people know, that it is addicting. But there's a small group that sees themselves as, Oh, I'm smoking because I enjoy it and I can quit anytime I want to. Then when we ask them to quit for a week or a short period of time, they come back and they are somewhat surprised that they had difficulty quitting.
Q. But whether the person believes he or she is addicted varies from person to person, obviously?
A. To some degree.
Q. Some people believe it and other people don't?
A. Yeah. But I just want to make sure that you don't imply that is 50/50, yes or no.
Q. Oh, no. I didn't mean to imply that.

A. Because there is a small group that, in fact, might think that they are not addicted.
Q. I see. Okay.
MR. GOLDBERG: Is this a good time?
MR. ROWLEY: Any time you want a break you just say so.
THE DEPONENT: It's 11:30. This would be a good time.
(Break.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Doctor, I'm not interested in conversations that were small talk or discussions about the weather or anything like that. Did you discuss with the plaintiff's lawyer your testimony or the subject matter of the questions or the deposition itself during the break?
A. No. I did not.
Q. I know you're not a medical doctor, but you know that there are various conditions that can cause depression?
A. Yes.
Q. You're not a medical doctor, but you

know there are various conditions that can cause insomnia?
A. Correct.
Q. You're not a medical doctor, but you know there are various conditions that can cause

irritability?
A. That's correct.
Q. And you're not a medical doctor, but you know that there are various conditions that can cause frustration and anger?
A. Yes.
Q. And there are various different conditions that can cause anxiety and difficulty in concentrating and restlessness and decreased heart rate and increased appetite or weight-gain; right?
A. Correct.
Q. I'm assuming -- correct me if this is wrong. It may well be wrong -- that one of the reasons that it is essential to have a physician do a physical examination as part of the evaluation that we have been discussing is so that the physician can assess whether a particular patient's mood or insomnia or irritability or anxiety or difficulty concentrating or restlessness or

decreased heart rate is attributable to something other than nicotine dependence or cessation. That is one of the reasons?
A. That is probably -- I'm trying to think exactly. I think, because most of those are specifically related to tobacco, in other words, we mentioned other things that can cause that. But when the question is probed such that, Last time you tried to quit what did you experience, and they mentioned some of those withdrawal symptoms, I think the counselors may, in fact, list that or note that.
And the physician looks at that eventually when they do get into the entire center, or once they are officially admitted and they start trying to quit smoking.
So, yes, I think that's something the counselor, whomever is taking it, who ultimately does it, that they take a look at that as well.
Q. So both the physician evaluates -- excuse me. Let me rephrase.
The physician evaluates it, and then the counselor has the benefit of the physician's evaluation in making this assessment?

A. It's the other way around, in the sense that --
Q. I see.
A. -- when the counselor collects that information, it's just like nurses do the work and they present it to the physician --
Q. Got you.
A. -- and the physician makes some determinations. Because he typically doesn't work with every patient, other than the physical. He doesn't do the little workup, the medical history and those types of things.
Q. So if the physician sees a patient who has complained about anxiety and has told the interviewer or the social worker or the nurse that he has anxiety, and the physician discovers that this person has an anxiety disorder or a panic disorder or some other medical condition that leads

to anxiety, that is something that you expect the physician to take into account; right?
A. I guess into what account?
Q. Take into account in assessing the person's status.
A. Whether they are addicted or not

addicted?
Q. That would be part of it.
A. Only a very, like I said, a small part, yes. That information is collected, and then the physician goes over it. Then he may, in fact, like you say, it may be a panic disorder, he may recommend them for a different kind of treatment, some kind of a psychiatry treatment or something. But, basically, they usually related to the smoking withdrawal. And, yeah, he could recommend and make a decision. He does periodically.
Q. What you are saying is that's part, I think you said it is a small part of the assessment, of dependence; but it's not the whole assessment?
A. That's true.
Q. That's true with respect to these other symptoms of withdrawal; the physician may seek to ascertain whether there are medical reasons for these symptom other than smoking-cessation? Sometimes there will be; sometimes there won't be. Is that right?
A. I don't know exactly how he goes about it or what either of the physicians would do. But

if he sees something like anxiety or something, he may ask a, probe a question or two, and make a determination very quickly, No, this is tobacco-related, or maybe some other problem or something. So he does, in fact, do that. I'm sure he does.
Q. Whether a person's dysphoric or depressed mood is attributable to some medical problem that has nothing to do with tobacco depends on whether the person, in fact, has another medical problem, it depends in part on that, that can lead to dysphoric or depressed mood?
A. Yes. I think you could, I mean, you could say yes on that. I guess I could. Excuse me.
Q. Some individuals have medical problems that have nothing to do with tobacco use that lead to depressed mood, and many individuals do not?
A. Uh-huh.
Q. Is that true?
A. Uh-huh. I think that's fairly accurate.
What we typically find when you look at the literature is -- I wish I had those numbers,

and I could share them with you, because I have them on the slide periodically -- when you look at depression, what we find, as a group, smokers are much more depressed in general as a group.
As a matter of fact, researchers found that when younger people, when they are depressed

as teenagers they are much more likely to smoke than if they are not depressed. Some people think because they're self-medicating, possibly.

So depression plays a part not only in them initiating smoking, but when they go through withdrawal that's a typical withdrawal symptom, is they might experience depression.

So depression plays very much a part.

So in some ways we are incredibly fortunate to actually have a physician who is, again, board certified in psychiatry and internal medicine. He can make both of those judgments there and make referrals or whatever.

Q. Some smokers are depressed; other smokers aren't depressed?

A. Yes. I would say the majority of smokers -- and I'm generalizing here, and I can't quote you that number. I could go find it -- but

we can typically say that smokers as a group are much more depressed. Because when we do all the clinical trials we'll always give -- which I mentioned before, which is a SCIDS or a Beck Depression Inventory -- and we find that smokers in general, as a group, are much more depressed than the normal population. That's not to say they are bad or anything or whatever. But as a group they are typically more depressed.

Q. Subject to the explanation that you just gave, it is true that some smokers are depressed and others are not depressed?

A. Yes. Again, just wanted to make sure that it's not yes or no. But there's a smaller portion that are not depressed, where a larger portion are depressed.

Q. I understand.

A. I just want to make that clear.

Q. But whether a particular smoker is depressed depends on which smoker we are talking about?

A. Sure.

Q. That varies from individual to individual?

A. Yes.

Q. Whether a particular smoker has a medical condition that is unrelated to smoking that causes insomnia depends on the smoker?

A. Yes. Because there could be some little subtle things that could cause insomnia other than withdrawal.

Q. Sure. There could be some major medical problem that causes insomnia?

A. There could.

Q. For example, somebody could have a bad back that causes them pain and keeps them up every night?

A. Yes.

Q. Whether somebody has a condition like that depends on who the patient is?

A. Uh-huh. That's entirely true.

But, typically, because in the probing that is what the counselor will do, and that's what

the physician will do. They'll actually inquire. And if it's related to their back, or they are saying, I've been smoking the whole time, that they were experiencing that, they may make that association as opposed to, No, I experienced it

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specifically when I have tried to quit. And there are different, so there's different associations. So even though there's some subtle differences, through proper probing they can usually determine what it is.

Q. Understood. And that particular type of probing, how much of it there is and what type is appropriate varies from individual to individual, depending on their circumstances and what they say?

A. Yes.

Q. Whether somebody has a medical condition or some other condition unrelated to smoking that causes irritability or frustration or anger varies from person to person?

A. Yes.

Q. Whether somebody has difficulty concentrating for reasons that are unrelated to smoking or smoking-cessation or attempts to quit varies from person to person?

A. Yes.

Q. It's an individual issue?

It's assessed on an individual-by-individual patient-by-patient basis?

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A. Yes.

Q. Whether a person has restlessness for reasons utterly unrelated to smoking nicotine or smoking cessation is an individual issue that's assessed on a patient-by-patient basis?

A. Yes.

Q. Whether a person has decreased heart rate for reasons that are unrelated to smoking, nicotine or smoking-cessation is assessed on an individual patient-by-patient basis because it's an individual issue?

A. Correct.

Q. Whether a person has increased appetite for reasons unrelated to smoking nicotine or smoking-cessation is an individual issue that is assessed on a patient-by-patient basis?

A. Correct.

Q. Whether a person has weight-gain for reasons that are unrelated to smoking nicotine or smoking-cessation is an individual issue that is assessed on a patient-by-patient basis?

A. Correct.

Q. The extent of each patient's motivation and the strength of that motivation is

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an individual issue that's assessed on a patient-by-patient basis?

A. Correct.

Q. The particular CO levels of each patient is an individual issue that's assessed on a patient-by-patient basis?

A. Correct.

Q. What diagnostic studies as a part of the physical examination are performed is an individual issue that is assessed on a patient-by-patient basis?
A. That's correct.
Q. Each person's medical history, including psychiatric or physical problems, is an individual issue that is assessed on a patient-by-patient basis?
A. That's correct.
Q. What answers each patient will give to each battery of tests that you provide is an individual issue that is assessed on a patient-by-patient basis.
A. What answers?
Q. Yes. What answers they choose to give.

A. Uh-huh.
Q. The particular approach in having the conversation with the patient for purposes of assessing nicotine dependence or addiction is an individual issue that's assessed on a patient-by-patient basis?
A. Yes, correct.
Q. Let's talk briefly about the DSM criteria for substance abuse. Let me show you the book. And, actually, if you would take a few moments to review that, I want to make sure that you're refreshed on it before we discuss it. I appreciate it.
MR. ROWLEY: We can go off the record while he is reviewing it.
(Off the record.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Doctor, tell us what is the DSM-IV, the book that you have in front of you?
A. Basically, it is a diagnostic, it's just a manual mental disorders. It's typically what people refer to.

Q. That's a book of criteria that are used by many medical professionals to diagnose disorders?
A. Correct.
Q. And you have had a chance to review the criteria for substance abuse that is sitting on the table in front of you?
A. Uh-huh.
Q. Is that right?
A. I have read it, just perused it very quickly.
Q. Let's take a look at criterion A. The first thing it says is, A maladaptive pattern of substance use leading to clinically-significant impairment or distress. That's the first clause of that sentence. Did I read that right?
A. I think probably so.
Q. Let me, let's make sure.
A maladaptive pattern of substance use leading to clinically-significant impairment or

distress.
Did I read that right?
A. Yes.
Q. Doctor, whether an individual has

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significant impairment is a question that is answered on an individual basis. Some people do; some people don't?
A. Yeah. I'm sure the -- I just need to make one thing clear. In the DSM-IV, even though I use the tobacco portion and it's my, in my work and so forth, I don't feel that I am an expert at really getting to other substance abuses.
As you said, this is something that physicians use; and it is clear that I'm not a physician. So I'm really only concerned with the tobacco portion of this as opposed to the entire issue of substance abuse. I'm not a psychiatrist or pharmacologist or whatever.
Q. Right. What you're saying is that you're not qualified to apply these specific criteria; you apply another set of criteria that incorporates many of the notions that are in the DSM-IV?
A. I think what we do is we primarily concentrate on the tobacco portion. And I don't know if that's quite saying the same thing, but we, and I'm sure I have read or looked at this once before, just to get kind of a general

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understanding. But, again, I'm not a psychiatrist. I'm not a physician. We are experts in actually treating people that have been addicted, or the nicotine-dependent patient. So that's what we do.
Q. I understand. Turn to page 243, but keep -- We are just going to ask you just one or two questions on 243.
A. 243?
Q. 243.
A. Okay.
Q. Do you see section 305.10?
A. Yes.
Q. That's titled Nicotine Dependence?
A. Uh-huh.
Q. That section consists of a paragraph?
A. Uh-huh.
Q. Go ahead and look at it. Turn the page, look at the next page.
The section on nicotine dependence consists of one paragraph; right?
A. Uh-huh.
Q. You have to answer verbally.
A. Yes. I'm sorry. It does.

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Q. The first sentence of that paragraph is also referring to the text and criteria for substance dependence, see page 176.
A. Correct.
Q. There are no, there is no independent set, no separate, different set of criteria for nicotine dependence listed under 305.10. There are only comments.

A. Correct.
Q. So under DSM-IV, the criteria for nicotine dependence are, in fact, the substance-abuse criteria that are contained on page 182, because that's what they refer back to?
A. Yes. It appears they want you to go back and glance at that one as well.
Q. Right. Subject, of course, to the comments under 305.10?
A. Correct.
Q. Let's go back to 182, since we now know we have the right set of the criteria for assessing nicotine dependence.
A. Uh-huh.
Q. And we will go back to the question that I asked. Whether a person has clinically-

significant impairment is an individual issue that varies from patient to patient?
A. Uh-huh. I will agree with that.
Q. Is that correct?
A. Uh-huh.
Q. Whether a person has clinically-significant distress is an individual issue that varies from patient to patient; right?
A. Yes. I think I would agree with that.
Q. Then it says, the next clause of the first sentence, As manifested by one or more of the following occurring within a 12-month period: Recurrent substance use resulting in a failure to fulfill major role obligations. That's part of A1, the first part of A1.; is that correct?
A. Correct.
Q. Whether a person has recurrent substance use resulting in a failure to fulfill major role obligations is an individual issue that varies from patient to patient?
A. Yes. That is probably true.
Q. Whether a person has recurrent substance use resulting in a failure to fulfill major role obligation at work specifically is an

individual issue that varies from patient to patient?
A. Yes.
Q. Whether a person has that problem with respect to schools specifically varies from patient to patient?
A. Yes.
Q. Whether a person has that problem with respect to their home life varies from patient to patient and is an individual issue. That's true?
A. Yes.
Q. And we know that these things vary because some patients, for example, are in school and others aren't?
A. Uh-huh.
Q. And we know that some patients work and others don't; correct?
A. That's correct.
Q. That's why these are individual issues that vary from patient to patient, one of the reasons; right?

A. Yes.
Q. Now look at A2, which is on page 183.
A. Yes.

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Q. It says, Recurrent substance use in situations in which it is physically hazardous, for example, driving an automobile or operating a machine when impaired by substance use.
A. Uh-huh.
Q. How recurrent a person's use of nicotine is is an individual issue that varies from patient to patient; is that right?
A. Repeat the last little portion again.
Q. Yeah. I'm sorry. How recurrent, exactly how recurrent the use is is an individual issue that varies from patient to patient?
A. Yes. I will agree with that.
Q. Look at A4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance, for example, arguments with spouse about consequences of intoxication, physical fights.
Did I read that correctly?
A. Yes. I believe so.
Q. Whether a person, a particular patient has persistent social problems is an individual issue that varies from patient to patient?

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A. Yes. You can generalize to a certain degree. But, yes, it varies from patient to patient.
Q. Whether a person has recurrent social problems is an issue, an individual issue that varies from patient to patient; right?
A. Yeah. That's correct.
Q. How recurrent those social problems are, if they exist, varies from patient to patient and is an individual issue?
A. Correct.
Q. Whether a person has persistent interpersonal problems is an individual issue that varies from patient to patient?
A. Correct.
Q. Whether a person has recurrent interpersonal problems is an individual issue which varies from patient to patient?
A. That's correct.
Q. Of course, even among those people who have persistent or recurrent interpersonal problems, the nature and extent of those problems differ from person to person; right?
A. That was a really long one. Could you

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repeat that one?
Q. Sure.
Even among people who have persistent or interpersonal problems, excuse me, persistent or recurrent interpersonal problems, the nature and extent of those problems differ from person to person?
A. Yes.
Q. And therefore that, too, is an

individual issue that varies from patient to patient?
A. Yes.
Q. And among people who have these kinds of problems, whether social or interpersonal, whether persistent or recurrent, whether those problems are caused or exacerbated by the effects of the substance is a question that is an individual issue that varies from person to person?
A. That is correct.
Q. How those problem are manifested is an individual issue that varies from person to person; right?
A. The problems. What problems?

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Q. The social or interpersonal problems. Is that right?
A. Yeah. That's correct.
Q. Some people may have arguments with their spouse about smoking in the house; others may not. Right?
A. That's true.
Q. It depends on their spouse's attitude toward their smoking?
A. Correct.
Q. That is relevant to criterion A4 of DSM-IV, section, the section on substance abuse starting at page 182; correct?
A. Correct.
Q. And these are the criteria for assessing substance abuse in DSM-IV; correct?
A. Correct.
Q. Then B, the second part of the criteria, says, The symptoms have never met --
Okay. I don't think -- I think we've spent enough time on that. We don't need to go through this. Okay. Very good, Doctor. Thank you.
A. Do you need this back?

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MR. GOLDBERG: Let me look at that.
MR. ROWLEY: Plaintiff's counsel would like to look at it. That is fine with me.
THE DEPONENT: 182.
Q. Exhibit 14, the first question that I see on Exhibit 14 --
A. Oh, you are looking at it.
Q. Yeah.
-- is, How soon after you wake up do you smoke your first cigarette?
That question is, of course, familiar to you; right?
A. Correct.
Q. Because that question is asked as a part of the Fagerstrom Tolerance Questionnaire?
A. If I could just take a look at that.
Q. Unfortunately, we don't have a copy, so --
A. Actually, I think I have one of those if I can just --
Q. Why don't you pull it out.
A. Let me check and make sure. I think

it's -- well, if it is an identical one. Yeah.
Q. The complete name of the Fagerstrom,

of the revised version of the Fagerstrom test -- Well, let me repeal that.
One way to refer to the Fagerstrom test is Fagerstrom Test for Nicotine Dependence?
A. Yes.
Q. That, in fact, is how the Fagerstrom test is intended to be used, as part of the analysis or part of the assessment of whether an individual is dependent or addicted to nicotine?
A. Yes. That is one criteria that we use.
Q One among many --
A. Several.
Q. -- many necessary --
A. Yes.
Q. -- tests and evaluations --
A. Correct.
Q. -- and things of that nature?
So the first question is, How soon after you wake up do you smoke your first cigarette?
Did I read that correctly?
A. Correct.
Q. Some smokers have their first

cigarette immediately upon waking. Is that true?
A. Correct.
Q. Some have their first cigarette an hour or even two or even three or five hours after they wake?
A. Correct.
Q. The question of how soon after one wakes up that person smokes his or her first cigarette is an individual issue that varies from patient to patient?
A. Yes.
Q. The second question is, Do you find it difficult to refrain from smoking in places where it is forbidden?
That's the first part of the second part.
Some people do and some people don't; correct?
A. Correct.
Q. Therefore, the issue of whether the patient finds it difficult to refrain from smoking in places where it is forbidden is an individual issue that varies from person to person and patient to patient; correct?

A. Correct. But, again, you are pulling out each single question. Again, they may or they may not. But what we really are looking at ultimately is the composite score. What we really want at the bottom --
Q. I understand.
A. -- this one at the bottom, and then we look at, usually everyone feels, the researchers, the question that's most predictive whether a person is addictive is that number one. If someone

wakes up -- and some people wake up in the middle of the night and will light up a cigarette and then go back to bed. So those we have a tendency to say highly-addicted. When we come up with a composite score, even though there's some variation, if the composite score in combination with these other things -- you know, it's a big picture and not a little small piece of the puzzle.

Q. I understand.

A. I just wanted to make that clear.

Q. Whether a person has difficulty in refraining from smoking in church, for example, is an individual issue that varies from person to person?

A. Correct.

Q. The third question is, Which cigarette would you hate most to give up?

Did I read that correctly?

A. Yes.

Q. Some people would hate most to give up the first cigarette in the morning?

A. Correct.

Q. Others would hate most to give up the cigarette that they smoke after lunch?

A. Correct.

Q. Others would hate most to give up the cigarette that they smoke after dinner?

A. That's correct.

Q. Some people would hate most to give up the cigarette that they smoke after some other activity; right?

A. Yeah. Correct. And all of those are listed under Any Other.

Again, what we are trying to get at there is the first cigarette in the morning, because if they find there is a direct relationship with it, as soon as you light up, there is a tendency to be more addicted.

Therefore, all the others in all those different situations you gave really fall under Any Other.

Q. And that's part of the test for nicotine dependence?

A. Yes.

Q. Which you equate with addiction?

A. Correct.

Q. Which cigarette any one individual or patient would hate most to give up is an individual issue which is assessed on a patient-by-patient, individual-by-individual basis?

A. Correct.

Q. The next question is, How many cigarette per day do you smoke? Correct?

A. Correct.

Q. Some people smoke one cigarette a day; other people smoke a pack a day. Correct?

A. Correct. They could.

Q. Some people smoke more than 26; some people smoke less than 26.

A. Correct.

Q. The question of how many cigarettes

per day a smoker smokes, which is part of the test

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for nicotine dependence, is an individual issue that varies from patient to patient?

A. Correct.

Q. The next question is, Do you smoke more frequently during the first hours after waking than during the rest of the day?

Did I read that correctly?

A. Correct.

Q. Whether that is true or not, whether the answer to that question is yes or no, is an individual issue which varies from patient to patient?

A. Correct.

Q. The next question is, Do you smoke if you are so ill you are in bed most of the day?

Did I read that correctly?

Do you smoke if you are so ill that you are in bed most of the day?

A. Correct.

Q. The issue of whether the answer to that question will be yes or no is an individual issue; correct?

A. Correct.

Q. It varies from patient to patient;

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correct?

A. Uh-huh.

Q. You don't know the answer to the question until the question is asked; correct?

A. Correct. Well, that's, I mean, in the course of discussions someone may say that or whatever. But for actually recording, this is when it is actually done, because the patient will come in and they will start talking to you beforehand. So they may, in fact, say something there. But probably the first time, most of the time that you hear it is, in fact, on this questionnaire.

Q. The next question is, Please give your brand name, type, for example, 100 light menthol, and nicotine compound. Did I read that correctly?

A. Correct.

Q. That is part of the test, one of the tests that you employ as a part of a whole battery of tests for assessing nicotine dependence; correct?

A. Yes. That one in particular has, I think, probably of the group that's the one that we probably pay least attention to, because of what we call compensatory smoking. In other words, I think

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that the, we look at the nicotine content of these cigarettes. And what we are finding is that some of them are high or low, and it really, it is an FTC machine that's actually smoking them; so they're not really smoked the way an individual would smoke them.

And compensatory smoking is people who compensate. They go to light or whatever.

So even though that's a very part small, again, of this overall thing, you can see that we are trying to cover virtually all of our

bases just to make sure. Because that's something we look at as well. But, again, that is part of one test within the overall diagnosis of nicotine dependence.

Q. And you have got to cover all the bases in order to do an adequate job of assessing nicotine dependence on an individual, case-by-case basis?

A. Yes. I think that is important.

Q. And the question of which brand is smoked by the patient is an individual issue that varies from patient to patient?

A. Correct.

Q. The question of whether the patient smokes 100 Light cigarettes is an individual issue that varies from patient to patient?

A. Correct.

Q. The question of whether the patient smokes menthol cigarettes is an individual issue which varies from patient to patient?

A. Correct.

Q. The question of the nicotine content of the cigarette smoked by the patient is an individual issue that varies from patient to patient?

A. That's correct, with virtually all of those are, even though they were broken down all individually, you can get that just by asking what type of cigarette you smoke. So it can be taken care of in five seconds very quickly.

Q. Got you. But the answer to that question varies from patient to patient?

A. Correct.

Q. And, therefore, is an individual issue.

Okay.

The next question is, How often do you

inhale the smoke from your cigarette?

Did I read that correctly?

A. Yes.

Q. That's part of the test for nicotine dependence which you use in turn as a part of an overall battery of tests and procedures for assessing nicotine dependence; correct?

A. Correct.

Q. Some people rarely inhale; correct?

A. Correct.

Q. Other people sometimes inhale?

A. Correct.

Q. Some people almost always inhale?

A. Correct.

Q. The question of how often a patient inhales the smoke from his or her cigarette is an individual issue which is assessed and must be assessed on an individual patient-by-patient basis; correct?

A. Correct.

Q. Now, is Exhibit 13 a previous version of Exhibit 14?

A. Let me take a look at it.

Q. I'm sorry. There you go.

A. Yes. Basically, let's see, the FTQ, Fagerstrom Tolerance Questionnaire, was the original one that was developed; and subsequently the FTND has been developed.

So the original one is your Exhibit 14 that was developed, and then Exhibit 13 is now the revised version. They just make some little subtle changes. As a matter of fact, in the research literature a lot of people will still use FTQ and FTND.

And we might, in fact, do both, because we try to look at some correlation. So, again, we, in fact, might do both of them. And they are pretty much the same thing, some little subtle -- you have some little more information.

I notice here on this one in particular, the one says FTND and the other one has FTQ, sometimes the pharmaceutical companies get a little confused, because they're both Fagerstrom, and they can put one on the other. Because as I look at this, even though one has six or eight questions, I think they got a little composite of the two together.

So these probably aren't the exact

ones, but you've got all the questions here for both of them.

Q. And we just covered each question specifically on Exhibit 14. I don't want to take --

A. The one with the eight questions?

Q. Yes.

A. Yes.

Q. I don't want to take the time to --

A. It's pretty much the same.

Q. I understand. I don't want to take the time to go through every single question on Exhibit 13. Suffice it to say that with respect to each and every question on Exhibit 13, the issue of the answer to that question is an individual issue, and the answer will depend upon who you ask; right? The answer will depend on -- let me rephrase that. That's a terrible question.

Different people will give different answers to the questions that are Exhibit 13; right?

A. Yes.

Q. Therefore, it's an individual issue that varies from patient to patient?

A. I guess you can say individual issue. When we get those questions, basically, let me just go a little bit further and tell you what we do with this.

Once we have taken this questionnaire, usually the breaking point is around seven; if they score seven or higher, then they're seen as high dependent, or six or below then they're seen as low dependence. In other words -- and, again, this is one of the many tools that we have together to actually determine the level of dependence in that individual.

Q. The cumulative score or total score from the CRF number 2 test will vary from patient to patient?
A. Yes.
Q. The cumulative score or total score from the FTQ test will vary from patient to patient?
A. There is a certain amount of variance, not great. You could just, you could add up the scores, you know, you could see, one, one, three, here, two, four, five, six, eight, nine, ten, eleven. So the 11 is the high score. So, again,

anyone scoring seven or higher is considered nicotine-dependent.
Q. Got you.
A. On the other one, I think maybe the FTND that you've got there breaks it a little bit low for high dependent. And I think it's the one that you are actually looking at in 13. It breaks it down a little differently. But typically we use the seven as the marker.
Q. Right. But the point is some people will score zero --
A. And some people will score -- I mean, well, they could score a zero. But, typically, since they are smokers, I don't know if anyone will score, I mean, I guess zero-people have come in because they need assistance with their smoking.
Q. Look at Exhibit 14, which has the eight questions.
A. Is this the one I'm holding?
Q. Yes.
A. Yeah, the eightI, sure.
Q. The eight questions.
A. Sure.
Q. It's, one of the choices, and, in

fact, for some questions two of the choices are zero. So it's entirely possible for somebody to score zero?
A. Oh, sure. It's entirely possible. But, typically, people that come in are smokers and they are seeking assistance for smoking, or whatever, or they have been referred to us. So I guess you could say the score could go, theoretically, from zero to eleven.
Q. Whether the score will be zero or not is an individual issue that varies from patient to patient?
A. Yes.
Q. Whether it is 11 is an individual issue --
A. Sure.
Q. -- that varies from patient to patient?
A. Correct.
Q. And whether it is some number in between is an individual issue that varies from patient to patient?
A. That's correct.
Q. Do you agree that there are a lot of

factors that influence people's decision to start smoking?
A. Yes.
Q. And there are many factors that influence whether a person will continue to smoke?
A. I guess I would, sort of a little unsure there. In other words, my position is very simple, and I've, or at least felt this way very much in the past few years, that when you look at the literature, people start smoking because of peer pressure or the adult model or high risk-taking behavior, or to feel good.
So there's a variety of reasons, and different surveys find different things. But my opinion is that people smoke for a variety of reasons.
But once they get hooked on tobacco, and I can't tell you when it happens, at one or ten cigarettes or whatever, so I can't tell you when, but then the reason changes.
So the response to your question is people do start smoking for a variety of reasons; but when they get hooked they don't continue to smoke for a variety of reasons, in my opinion.

In my opinion and professional judgment, I think that thereafter they continue to smoke because of the addiction. In other words, they make, they start smoking to feel good. Once they get hooked they no longer smoke to feel good. Now they smoke to keep from feeling bad because they would experience withdrawal or begin to experience some of these other things that we have been talking about, but typically the withdrawal symptoms.
So, I think, yes to the first that I mentioned; and the latter one it's not quite clear-cut.
Q. And the extent to which all of those things that you just described is true with respect to any individual patient is an individual issue that varies from patient to patient because some patients are dependent and others are not; right?
A. True. I mean, some smokers, I imagine, if you smoke one cigarette you could say that that person is not dependent or something. But, yes, I think that's probably pretty accurate.
Q. One of the things that you assess that we have discussed very much at length in

determining whether someone is nicotine-dependent is the extent of their motivation. There are, in fact, a whole host of other factors that affect their extent of motivation.
A. What was the last little part of that?
Q. There are, in fact, a whole host of other factors that affect each individual's extent of motivation, that affects how motivated they are.
A. Yes. I mean, someone, what we find is when people come to the center the people that are the most motivated are people that have recently experienced a heart attack, or having some medical condition, I just should say. Those are the people

that are highly motivated because they have finally seen something that has occurred and they want to do something about it. So those tend to be the people that are very motivated.

Q. There are, of course, many factors that can affect motivation which, in turn, can affect the assessment of whether somebody is dependent? For example, regulations that prohibit smoking in certain environments can affect someone's motivation?

MR. GOLDBERG: Object to form.

A. Yes. I think probably so, yes.

Q. Peer approval or disapproval of the smoking habit can affect motivation?

A. Motivation to initiate smoking or to continue smoking?

Q. Motivation to stop.

A. To stop? Could you repeat the question?

Q. Yeah. Peer approval or disapproval can affect the motivation to stop?

A. Yes. I am sure it could.

Q. Familial approval or disapproval could affect the motivation to stop?

A. Yes.

Q. Whether one's peers smoke or not could affect the motivation to stop?

A. Correct.

Q. The extent of the person's education can affect motivation to stop?

A. Yes. I'm sure typically what the research finds is the more educated you are the less likely you are to smoke and the more likely you are to quit. And the reverse is also true, the less educated you are the more likely you are to

continue smoking and the less likely you are to quit.

So it is correlated with education. But I don't know if it's, I don't know the way you stated it, but I think I have answered that. I'm not sure.

Q. You most certainly did answer it.

The extent of each person's education is, of course, an individual issue that varies from patient to patient?

A. That's correct.

Q. And whether ones peers approve or disapprove of one's smoking is an individual issue that varies from patient to patient? Some people's peers approve, other people's peers don't approve?

A. Yeah. And, again, you are asking me about quitting, are you asking, is this a quitting question?

Q. Yes.

A. Yes.

Q. And peer reaction to smoking is an individual issue that varies from patient to patient?

A. That's correct.

Q. Socio-economic status has been tied in

the literature to motivation or to success in quitting?
A. Yes.
Q. And, of course, the question of socio-economic status is an individual issue that varies from patient to patient?
A. Correct.
Q. Some people have high socio-economic status; correct?
A. Correct.
Q. Some people have low; correct?
A. Correct.
Q. Things like school performance, participation in sports and other activities are known to affect whether people continue to smoke or not smoke?
A. I guess I'm not quite sure. I notice -- are you asking me two questions or one?
Q. No, just one question.
A. Could you repeat that?
Q. Factors such as participation in sports, for example, may affect someone's motivation to stop smoking?

A. True. I think in my case, because I was an athlete, I chose not to smoke, or thought that it was detrimental or whatever in my case in terms of sports.
But there was a second part of that you mentioned?
Q. I rephrased the question.
A. Okay. I'm sorry.
Q. And you have answered it, which I appreciate.
So you have actual personal knowledge of that from your own experience with sports?
A. I don't know about knowledge, but that was a personal decision for me. So I am sure if I did it it was for others as well.
Q. Whether a person participates in sports or doesn't is an individual issue that varies from person to person?
A. That's correct.
Q. Self-esteem can affect motivation to quit. I think you have said that.
A. Sure. Yes.
Q. The level of each person's self-esteem is an individual issue that varies from person to

to person, isn't it?
A. Yes.
Q. How rebellious the person is may affect their decision to quit or not to quit and may affect their motivation to quit or not to quit?
A. That is correct.
Q. Which, in turn, is part, as we have discussed, in assessing whether they are dependent or addicted?
A. Correct.
Q. Whether a person is rebellious or not is an individual issue that varies from person to person? Some people are rebellious; other people

aren't?
A. Correct.
Q. Whether a person is a risk-taker can affect his motivation to stop smoking, which, in turn, is taken into account in assessing dependence; correct?
A. I don't know about, that one is a little different in terms of --
Q. I will rephrase. That was a confusing question.

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Whether a person is a risk-taker can affect his motivation to quit? Make it simple.
A. I am sure that there is. I guess usually that's associated with initiated smoking in terms of risk-taking behavior, because when you want to quit that's usually not a risk-taking behavior. That's initial, you know, when you are starting to smoke, that's a risk-taking behavior.
Q. I'm sorry. That was probably a bad question. You misunderstood it. It was probably my fault.
Risk-takers are more likely to continue to smoke than people who are not risk-takers?
A. I think that that is probably true.
Q. Therefore, risk-taking affects motivation to quit?
A. Yes.
Q. Whether someone is a risk-taker or not is an individual issue because some people are and some people aren't?
A. Correct.
Q. And among people who are risk-takers the extent of their aversion to risk varies from

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person to person?
A. That's correct.
Q. The extent of aversion to risk is an individual issue that varies from person to person?
A. That's correct.
Q. You mentioned earlier that some people self-treat psychological conditions that they have with cigarettes and with smoking. In fact, I know you have published that. So you have mentioned it today and you have also published it; is that correct?
A. Yes.
Q. For example, some people with major depression self-treat with cigarettes to make themselves feel better. That's true?
A. I think that's a common theory, where people, the word terminology is self-medication.
Q. The question of whether someone is self-treating or self-medicating, as you have said, is an individual issue that can be assessed only on an individual-by-individual, patient-by-patient basis, because some people do it and other people don't; right?

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A. That's true.
Q. Some people have conditions for which

they can self-treat, while other people don't have those conditions; right?

A. You mean smoking conditions or conditions outside of smoking?

Q. Depression, for example. Some people have it; some people don't.

A. That's true.

Q. People who don't have it can't self-treat with cigarettes, because they don't have it; right?

A. Oh, that's, I mean, that's true, but that's not, depression isn't the only reason that, you know, people continue to smoke or self-medicate.

But that's a common feeling among the researchers, that some people will, in fact, self-medicate, because, as you know, one of the withdrawal symptoms that you went over just a while ago, was, in fact, depression. And that's very common for most people.

So, in fact, one of, the thinking is that, in fact, that may be where they are

self-medicating.

Not everybody will experience depression when they quit, I guess, is what I'm trying to say. I wasn't very clear.

Q. Actually, it was clear. And that's one of the things that makes it an individual issue, because not everybody has it?

A. Correct.

Q. Gender has been associated with people's extent of motivation?

A. Yes. I am sure there would be some differences if you compared males to females.

Q. Right.

A. Because they would not be identical.

Q. Right. And, of course, whether someone is male or whether someone is female varies from person to person and is an individual issue?

A. Correct.

Q. A person's beliefs about smoking can affect his or her motivation to quit?

A. Yes.

Q. And beliefs about smoking are an individual issue that vary from patient to patient; different patients have different beliefs?

A. Correct.

Q. A person's employment status can affect his or her motivation to quit smoking; right?

A. A little further on that one. I'm not quite sure.

Q. Someone who is unemployed and at home and can smoke whenever they want may be motivated or have different motivations than someone who is employed in an environment where smoking is prohibited?

A. True.

Q. People's employment status vary from person to person. Some people are employed, some people aren't?

A. Correct.
Q. That's an individual issue that can be assessed only on a person-by-person, patient-by-patient basis; right?
A. Correct.
Q. Even among people who are employed, some people work in environments where smoking is prohibited and other people work in environments where it is permitted; right?

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A. Uh-huh.
Q. Correct?
A. Correct.
Q. That's an individual issue that can affect motivation and that can be assessed only on a patient-by-patient basis?
A. Yes. That's motivation to quit as well?
Q. Yes.
A. Yes. All of those factors are pretty much to quit. But, basically, when they come to us they are either a smoker or a non-smoker, I mean, they are a smoker, and then they are dependent or not dependent, and they're high and low dependence.
So even though there's a whole group of people that are, in fact, coming in that you are bringing in ultimately, we make some different kinds of decisions.
And all of that information is collected within a much shorter period of time.
There's a lot of variations, but ultimately they wind up being determined whether they are addicted or not addicted.
MR. GOLDBERG: Do you want a break?

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MR. ROWLEY: Do you want to break?
THE DEPONENT: Actually, believe it or not, I need to go to the bathroom one more time. I think it is probably the constant sipping of the water because my mouth is dry.
MR. ROWLEY: Let's take a break.
(Break.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Doctor Glover, please take a look at page 1 of your original report in this case, which is the IBEW report.
A. Is that an exhibit per chance? No?
Q. I believe it is Exhibit 1.
A. Okay.
MR. GOLDBERG: Did you find it?
THE DEPONENT: Yes, sir. Okay.
Q. Do you see the last full paragraph on page 1?
A. Yes.
Q. You say, Smoking is the leading preventable cause of death in the United States.
A. Correct.

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Q. What is the empirical basis for that assertion?
A. That assertion -- obviously, I didn't

do the study or the research. The empirical basis is basically you can see the reference that I'm referring to, and that is the Health Benefits of Smoking-Cessation, a Report of the Surgeon General, 1990, Rockville, Maryland, Department of Health and Human Services, Centers for Disease Control, Center for Chronic Disease Prevention, and Health Promotion, Office of Smoking and Health, 1990, DHHS, publication #CC90-8416.

Q. Does that document, that is to say reference number 3, describe the empirical basis for that assertion?

A. I don't recall exactly if it does or not. That number I basically got from those documents. I don't, can't remember exactly what studies or how it was collected or whatever. Basically, that's a fact that I pulled again from the Surgeon General's report. I did not participate in the study. I don't know about it. I didn't go in to see how they inquired, how they collected the data.

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Q. When you say "that number," you're talking about the 400,000, the supposed 400,000 deaths that are referenced in the next sentence?

A. Correct.

Q. So you don't know what scientific methodology, if any, was used in estimating that number?

A. Correct.

Q. You haven't assessed whether the methodology, if any, that was used in arriving at that number was, in fact, scientific?

A. Correct. I just, again, the assumption I was going on is that because it was in the Surgeon General's report, that it, in fact, was correct. I didn't go out and check and count every individual smoker or death or whatever. I just assumed that those numbers were, in fact, correct.

Q. You did nothing, in other words, to assess whether they are, in fact, correct?

A. Correct.

Q. Did you do anything to determine whether that particular estimate or estimates of that type have been criticized in the literature before you put that assertion in your report?

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A. I guess I'm not quite sure what you're asking.

Q. Did you look in the literature to see whether any scientists, medical people or other experts have said that the 400,000 deaths estimate is bogus?

MR. GOLDBERG: Object to the form of the question.

Q. Did you do that?

A. No. I did not.

Q. Did you look in the literature to determine whether that supposed estimate has been called a lie?

A. No. Actually, I think that probably depends on who you are looking at. I picked, again, a federal document, the Surgeon General's

report. Some people even note that number to be higher than that. I try to be a little more conservative. I think they'll go up to as high as 500,000. So the number I used was, again, what I perceived to be, was from the federal government. I think in that one, let me look at 6 just to make sure of my reference.

That reference in particular comes

from Houston, Eriksen, Fiore and Jaffe. No, that's the secondhand one, but 5, Centers for Disease Control and Prevention, I thought.

Q. Yes.

A. So that actual number comes from CDC.

Again, all I'm trying to do is, when we report this, because I don't go out and replicate all the research that's been done before, or even attempt to. There are some things that are published that need to be accepted as fact, or in refereed journals or in publications coming out of the government, that emanate from there.

Basically, I just used that number when I was referencing or doing an introduction or review of literature. That's very common. Writers will do it quite often.

MR. ROWLEY: Could you, for my benefit, tell me what the question was, because I have forgotten it.

REPORTER: "Did you look in the literature to determine whether that supposed estimate has been called a lie?"

Q. Doctor, I appreciate the response that you gave me, and I'm here to get your thoughts and

to get information from you.

But I wonder if you might answer the question that I asked, and that is, did you look in the literature to determine whether this estimate or other similar estimates have been called a "lie"?

MR. GOLDBERG: Object to form.

A. What I have done, I haven't looked -- I would never get anything completed if every fact I saw I would have to investigate whether it was a lie or not. So I did not do this.

I have never heard anyone other than tobacco personnel or people that worked for the tobacco industry call it a lie.

I think most researchers maybe will differ. They'll say 500,000. And some may say 300,000, or 330, or whatever.

But I think the general feeling is that smoking is the leading preventable cause of death in the United States.

And the number in question, how many people die, there's some little variation in that. It depends on, you know, some people are quoting the American Cancer Society, some are quoting the

Heart Association, some the Lung Association, because we don't put an X on everybody's forehead that, in fact, does that.

So there's little survey differences,

and there's different years. Are you talking about last year's, whatever? But that's an approximate.

Q. What are the various alternative methodologies for reaching such estimates?

A. Again, I did not do this, and I don't do that. Basically, that was what was reported by the CDC, and that's basically what I reported as well. I didn't go in and check their methodology or what they did or whatever. That's not, to me, basically, I would never get anything completed if I had to check virtually everything and go back and replicate everything that's been published. Nobody does that.

Q. Are the methodologies, the basic scientific methodologies by which calculations like this are made within the scope of your expertise?

A. No. That's not what I do.

Q. You have never performed such a calculation?

A. No. I have never done, looked at the

number of people that died in the U.S. or performed any calculation relative to secondhand smoke. That's not what I do. That is epidemiology work or even statistician work. That's not what I do.

Q. And you're neither an epidemiologist --

A. No.

Q. -- nor a statistician; correct?

A. Correct.

Q. And the various shortcomings of whatever methodology was used to calculate this number are not within the scope of your expertise; correct? You don't even know what they are; right?

A. Yes. That is probably accurate. In other words, that's typically what, again, is reported.

And I would venture to say that any article that you read out there will mention numbers or whatever. Again, they may differ, but I think everyone would definitely agree that it is a number.

And I don't think, I would doubt there is one individual that could be someone that would actually go back and check the methodologies and

what happens.

Again, once something is published in refereed journals, that supposedly has already been taken care of. Three referees, or as many as five referees have, in fact, determined that it was scientifically valid, and someone has already done that.

You don't need to go back and replicate it every time you do a study. You would never get anything done. Nobody would.

Q. Doctor, did you know there's a whole body of literature that relates to the scientific methodology of making these types of estimates? Were you aware of that?

A. Yes.

Q. And were you aware that that body of literature is chock full of explanations and

debates and controversies over the methodologies that are used to make these types of estimates?
A. I am aware of that. But most of that, from my impression, is being led by the tobacco industry, because they don't particularly want these numbers to be there.
There is some literature there. But,

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again, I just have to have a certain amount of faith in what is being done. And I assume that CDC, in fact, took all the proper precautions and did that. I don't go back and double-check their data. And there is some data there.
Again, that's not what I do, and I have limited amount of time. And my time is spent on treating the nicotine-dependent patient. That's what we do. We diagnose and assess and so forth. Then we treat appropriately the nicotine-dependent patient.
I'm not an epidemiologist. I'm not a statistician. I don't go back in and double-check everyone's numbers and figures. Again, I don't know of anyone that does that. There just isn't enough time.
Q. The question of how many people die annually as a result of exposure to any particular risk factor is not within the scope of your expertise?
A. No. I typically use the research that's been published, and I present that. I don't go out and do that type of research. That's just not something that I do.

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Q. So if someone is going to testify in this case as to whether this number that you have put in your report is scientifically accurate, it is going to have to be somebody other than you because it's not within the scope of your expertise to say whether this number is scientifically accurate.
MR. GOLDBERG: Object to the question, compound question, plus asking this witness to make a legal conclusion that's for the Court.
Q. You can answer, Doctor.
A. Could you repeat the question, please?
Q. If I want to find out from an expert whether this number is correct scientifically or incorrect scientifically, and why, I would have to ask someone other than you? That's true?
A. Again, with the refereed journals, basically, what's happened, it's already been reported and someone else has already done that. So once it is accepted as fact, people would say that. I mean, people present those numbers.
And, again, you will see study after study. And that's the purpose of referencing. The purpose of referencing is so individuals can go

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back and maybe possibly go through that. And that's what an epidemiologist or a statistician would do.
And I'm sure that's what the tobacco industry has done. They have gone back and pulled

that in trying to look at the scientific merit of the manuscript in some way.

But once it's reported that it's X amount of numbers, if someone asked me how many people died, basically I would say, According to the CDC 400,000 people die a year prematurely.

I don't think there's a -- I'm assuming that it is done correctly. But beyond that, as far as how it was done and the rigors, you would ask someone else.

Q. If I wanted to find out whether the methodology used by CDC was scientifically valid, I would have to ask someone other than you?

A. Yes. The scientific and how it was done, correct.

Q. If I wanted to know the empirical probability that this estimate was off, that is to say, incorrect by a certain amount, by a certain percentage, I would have to ask someone other than

you?

MR. GOLDBERG: Objection, vague.

Q. Right?

A. Would you read the question?

Q. I will repeat it.

If I wanted to know the empirical probability that this estimate was off by, say, 5 percent or 10 or 20 or 50 or 100 percent, I would have to ask someone other than you?

A. I think that's correct.

Q. If I wanted to know the error rate in calculations like this, and by "error rate" I mean the percentage of the time that they're just flat wrong, I would have to ask someone other than you?

A. That is correct.

But that is typically what happens in refereed journals. In other words, it's been assigned to three, to as many as five people to, in fact, do that.

It isn't necessary for everyone to, in fact, go back and review every piece of literature. Once it's reported in the literature and it has been already looked at by several people, typically what happens in refereed

journals, that's the purpose. You don't go back and check those data every time. What happens is once it is reported, then other people will report that same number.

As I said, there's some little variation, depending on who is doing it or whatever. But as far as those calculations, if you want to know how they took place, how they occurred, looking at error rates and those types of things, that's not what I do. And that's not what I'm interested in doing. I have limited time, and my time goes into the diagnosis of nicotine dependence and how that comes about, and to treating that person.

Q. Has it been stated, Doctor, in peer-reviewed journals by persons who have no affiliation whatsoever with the tobacco industry that the estimate that appears on page 1 of your

report is scientifically invalid?
A. I don't know if these people have associations, or do not, excuse me, do not have associations with them.
And I'm sure that there would be some people. Just because, you need to be very clear,

but just because one or two people disagree, or five people or whatever number you are thinking of, even when we do research, if we do 12 or 15 studies, what we do, because one or two find something different, because there's always anomalies, what you do is you look at the body of literature. And the overwhelming body of literature, I can assure you, leans in 300 to 500,000 deaths. And it is there, giving a range or a number.
So that, I mean, the overwhelming gives you those numbers. So, in fact, it does, it does occur. So I'm sure there's always people that will disagree. But you need to go with the body of literature.
Q. What kinds of studies were these estimates, these 3 to 500,000 deaths, estimates, based on, Doctor?
A. Again, on the estimates, I can't go in and tell what you what the methodology was done and what was done and so forth.
But typically what has been reported in the literature, the American Cancer Society, the Heart Association, the Lung Association, the CDC,

and I'm sure, I mean, there's so many different groups, and health groups, and JAMA, excuse me, JAMA, physicians groups, and a whole variety of groups that will, in fact, do studies. So there is somewhere variability within that, and that's what I'm referring to.
Q. How many such studies have been done?
A. I couldn't even begin to tell you.
Q. Is it more than one?
A. Yes. More than one, but I couldn't tell you less than or more than or whatever. It is definitely more than one because there's different numbers. You will see that periodically.
What I try to be is consistent, is to try to stick basically with CDC. When we are looking at the number of people that smoke or the operational definition of what constitutes a current smoker, it is CDC.
And as long as you keep using these same numbers, you are safe. In my opinion, when you start getting in trouble or having a little difficulty is when you start crossing boundaries to prove a point.
I'm just sticking with CDC, because

that's what, in fact, CDC has said and how they define or given the operational definition of what a smoker is.
Q. What data set was this estimate based on?
A. As I told you before, that's not what

I do, and I don't do that. I could actually even almost care less, because someone has already done that. It's already been peer-reviewed, and I just simply don't need to do it. I don't have that kind of time.

Q. You understand, of course, that it occurs all the time that two articles with contradictory conclusions are published in peer-reviewed journals simultaneously?

A. Correct. That does happen. But --

Q. Doctor --

A. But what you also need to look, because one or two have contradictory, that isn't the body of literature.

What you need to do is look at -- I'm making this up -- at all the studies that are published. And when you see a trend or whatever, just because you do a study once, typically, most

researchers are a little skeptical. I mean, you look at it and you need to see a pattern or a trend. You need to see two studies, four studies, five studies. Then you say, Hey, this is, in fact, true.

So there are labels, certain numbers of deaths. I couldn't give you the names of all of these individuals or whatever, or who they are or how it was collected. But it is a well-known fact that people die from cigarette-smoking. Now, to the exact number, that would differ in how it collected. Again, I don't do that.

Q. You don't know from what data set these calculations were made. Can you tell us what kind of data set they were?

A. No, I cannot.

Q. Can you tell us when the data were collected?

A. Typically --

Q. I'm sorry. Let me clarify. Not when the report was published, but when the data upon which the assertion was based were collected.

A. Typically, I can't tell you when it was collected, or when the data were collected.

Data is plural. Basically, I can't tell you when it was collected, but it is definitely published. I can tell you when it was published, and it is usually, obviously, before that -- they collected the data and then published it. It usually takes, it could take a year, two years, before it is ultimately there. They'll usually reference it by saying in this year or that year, whatever. This is the actual publication where the number occurs at a certain time. And, no, I could not tell you when that data were collected.

Q. What was the sample size?

A. I think I told you I didn't participate in that. I didn't, I don't know that. That's not what I do. I'm not an epidemiologist. I'm not a statistician. That has been done or looked at by others through peer review. Then it's been published.

Again, that's where I pick up the

number. And then any introduction of most tobacco papers, people always mention about how many people have died or whatever. That's very typical. Again, I would doubt that you would find one of those researchers -- obviously, I can't say never,

never has, but the majority of them, in fact, take that number to be fact and then proceed with that.

MR. ROWLEY: Move to strike the speculation.

Q. Was this estimate calculated with a particular P value?

A. Again, I'm sure that it was. I mean, that would the case.

Oh, yeah. Anything has to have a certain amount of P value to make it. But I couldn't tell you what the P value is. I couldn't tell you what it was set at. I can't tell you how it were collected or how it was collected or whatever. So I simply, that's not something, that's not what I do.

Again, my expertise lies in the diagnosis and the treatment.

And you're asking a lot of questions relative to statistics and epidemiology and how data were collected that I don't even have access to. I don't think I could even request that data and get access to it. So to me it's a moot question.

Q. You did put it in your report?

A. Yes. Again, as I just mentioned just a moment ago, that number -- do you want me to repeat it again?

Q. No.

A. That number, in fact, has been collected. And it's been done by CDC. And I assume they took the stringent, did the proper, did the precision, and actually made sure that it, in fact, was correct and that data were collected.

I didn't participate in the data set or what the sample was. I did not analyze it. I'm not a statistician. I'm not a epidemiologist. That's not what I do. Once it is reported in the literature, then that's when I, in fact, would have noted that number.

Q. You don't know the empirical probability that this estimate is correct, do you?

A. No, I do not.

MR. GOLDBERG: Objection, vague.

Q. Why don't you tell us, Doctor, exactly what is a P value?

A. P value, again, I would prefer, that's an area of expertise. What I would prefer to do is, in fact, limit my testimony basically to what I

do rather than try to go into statistical or epidemiology work.

Q. Doctor, the fact is that you don't even know what a P value is?

A. That's your opinion. I have my own opinion.

Q. What is your opinion?

A. Huh?
Q. What is your opinion?
A. I think my expertise lies in tobacco and tobacco, trying to treat the nicotine-dependent patient. That's basically what I do.
I don't, I wasn't brought here to discuss P values. I wasn't brought here to discuss statistics or to discuss epidemiology. I was brought here to talk about treating the nicotine-dependent patient.
Q. Well, Doctor, you put a conclusion in your report that's a statistical and epidemiologic conclusion. Specifically, it is a biostatistical conclusion that used a specific roundly-criticized methodology. And that's why I'm asking you questions. Do you understand that?
A. Yes.

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Q. I'm asking you questions about your statement because you put this statement in your report.
A. Correct.
Q. And right now you're telling me that the question of whether this statement is correct or incorrect, whether it is valid or invalid, whether the methodology has been criticized or not, whether there are alternative methods of doing this that are more valid, all of these things are beyond the scope of your expertise.
MR. GOLDBERG: Objection. That's --
Q. That's true, isn't it?
MR. GOLDBERG: Just a minute. Let me finish my objection, please. Objection to the form of the question. It is vague and compound.
Q. All of those things are beyond the scope of your expertise?
A. Would you repeat the question?
Q. I'm not going to repeat the question.
A. I would like to note that you're not repeating the question when I request it.
Q. Why don't you tell me, Doctor, your opinion as to whether you understand what a P value

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is. What is your opinion? Do you think you do or do you think you don't?
A. Again, I think that's really irrelevant, in my opinion, mainly because I'm not a statistician, I am not an epidemiologist. I don't get into those areas. I discuss them. We talk about them or whatever. But I simply, that's not what I do, and that's my secondary expertise. My expertise lies in the treatment of nicotine-dependent patients.
Q. Dr. Glover, what is a P value?
A. I have already answered that.
MR. GOLDBERG: Objection, asked and answered.
Q. Do you know what a P value is?
MR. GOLDBERG: Same objection.
A. I already answered that.
Q. Should I infer from your response that you do know what a P value is, or should I infer that you don't know what a P value is?

MR. GOLDBERG: Same objection.
A. I have already answered that.
Q. You have?
A. Uh-huh. Do you want me to answer it

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again?
Q. If you give me a responsive answer. A responsive answer would be a "yes" by itself or a "no" by itself, or a "yes" with an explanation or a "no" with an explanation.
MR. GOLDBERG: Objection.
Q. If you will do that, I would like you to answer, yes.
A. I have answered the question. I just mention time again, I'm not an epidemiologist; I am not a statistician. Those are secondary interests in research areas of mine. My primary interest is in altogether a different area, and that's in the treatment of nicotine-dependent patients.
Q. Dr. Glover, do you know what a P value is?
A. I have answered that.
MR. GOLDBERG: Objection.
Q. Can you explain for us, please, how a P value differs from any other statistical concept?
MR. GOLDBERG: Objection.
Q. You can pick whichever statistical concept you would like.
MR. GOLDBERG: Objection, vague.

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A. I have answered that.
Q. You have?
A. Uh-huh.
Q. What other statistical concept did you compare it to when you answered that question?
A. I told you that I'm not a statistician. And this is the way I will answer this question, and hereafter when I say I have answered that. I am specifically referring that I'm not a statistician. I am not an epidemiologist. That's not what I do. When the data set are collected, I don't go in and go through the government's books or whatever to see what they are doing. When it's reported in journals, that 400,000 or 500,000, or whatever that number is, that, in fact, is the number that I would use.
As far as how it were collected, I don't get involved. I'm not a statistician. I don't get into that. That's not what I do.
When we work on projects, we always have statisticians that are on board, because you simply cannot be a thorough expert or a primary expert in so many areas. So what we do is we have

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a statistician that can deal with those questions. We have physicians that do physicals. We do counselors. There's a team that usually participates. Even though we all participate at some level, that's not what I do. That's left to epidemiologists and statisticians.
So when I quote that number, that's already been done by others and not by me.

Q. So just help me out. I'm trying to tease out of your answer which alternative statistical concept you are going to compare a P value to. Tell me which one it is.
A. I am not going to compare it to anyone. That's not what I do. You're asking me to compare statistics and to compare different statistical techniques, and that's not what I do. As a matter of fact, statisticians would do that, even as opposed to an epidemiologist. So that's just simply not what I do.
MR. GOLDBERG: Counsel, the deposition is -- just a minute -- the deposition is to conclude at 5:30. This is the second day of the deposition. We will object to any additional days of deposition, especially in light of the amount of

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time that has been wasted. But proceed at your peril in regard to whether you can or cannot finish.
MR. ROWLEY: Well, I have to say that that that's a very bold statement given the fact that this witness essentially refuses to answer certainly the majority of questions, requiring me to re-ask the question, in some cases 5, 10, 15, 20 times, and it is a rare occasion when I actually get an answer even when I re-ask the question.
So if you would like to take this before the Court with respect to whether we come back, I have to tell you, we would be absolutely delighted to do that, because I think the Court would enjoy reading this witness's utterly non-responsive answers and preposterous, laughable attempts to evade answering simple questions. So feel free to do that.
MR. GOLDBERG: I feel very strongly that your characterization is grossly incorrect and that it will be seen as grossly incorrect. But you proceed at your peril.
MR. ROWLEY: All right.
BY MR. ROWLEY:

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Q. Doctor, have you ever calculated a P value?
A. We have statisticians that, in fact, do that. They calculate the P values.
Q. You answered a question that was different from the one I asked. I will ask you again.
Have you, Doctor Elbert Glover, ever calculated a P value?
A. We always work with statisticians. In other words, we work closely with them and so forth. In other words, as far as maybe calculating it, if I use my pencil, my pen, and I did that, I would have to think about that for a moment. But typically we always have statisticians on the team that, in fact, do that.
Q. You have again answered a question that is different from the one I asked. So let me ask you again.
Have you, Doctor Elbert Glover, ever calculated a P value?

MR. GOLDBERG: Objection, asked and answered.
A. I answered that. I don't know what

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else you want me to do in the sense that I can't, I simply can't remember. I think in the beginning we may have done that.
Q. You say you can't remember?
MR. GOLDBERG: That's what --
A. Yes. I said that the first time when I said what happens --
Q. ...
A. Let me finish, please. You interrupted two or three times there.
I think what happened in the beginning, that we, in fact, I started doing that; but I realize over time that when you get more involved in research you need experts, a variety of experts that come to bear on a problem. Hereafter we always use statisticians. We always use epidemiologists. We have, specifically, statisticians. We tell them what we want done, and they basically will do it.
So maybe early in my career I was doing that, but now as director I basically request things be done. I don't do that. I'm not out on the firing line doing that possibly all the time. As, again, director you have people that work for

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you to do that sort of thing.
Q. As you sit here today, the method by which P values are calculated is not within the scope of your expertise?
A. I have answered that several times, and I can tell you that, again, that's not typically what I do. I can read them. I know, understand them, and things of that nature, to a certain degree. But that's my secondary expertise.
Again, my expertise is in a totally different area. It is not epidemiology. It's not statistician.
I'm sure you could ask me a lot of questions about geology, and you can ask me a lot of questions, other questions about sociology or whatever that I would not know as well.
That's just not my area of expertise. It is more of a secondary.
Q. Thank you.
Can you tell us how the concept of P values relate to the validity of the assertion in your report that we have been discussing?
A. Again, I will give you the identical same response. That, again, in terms of the

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P values, that is not typically what I would use. It's a secondary expertise. I don't get actively involved in calculating and punching in the numbers and doing all of that.
Our work is taken to the statistician who, in fact, enters it, and he does the work, or she does the work. And that's typically the way they work.
Everyone has a different part being on

the team. Again, being the director, I don't get in there. I am doing a lot of more administrative work or whatever. I simply don't do those things anymore.

And if you are at all aware, you know that statistics and techniques are constantly changing.

As epidemiology --

Yes, your eyes. I think, just for the noting of the camera --

Q. Surprised.

A. Noting for the camera again, I'd like to note that here you go making eyes and expressions again, trying to confuse me or confound me as usual.

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But, no, the statistical meta analysis is a perfect example, something that was relatively new in years past. So now when I went to school meta analysis was simply not done, or at least it wasn't discussed, and now it is there.

So you have to be on top of statistics. You have to be on top of all of that to be continuously sharing that information and being aware. I simply can't do it in ten different areas.

Q. So statistics is not something you are on top of? That's what you're saying?

A. Yes, possibly.

Q. And if I wanted to know the statistical shortcomings of this 400,000 death estimate, I would have to ask somebody like one of the statisticians who you work with. I wouldn't be asking, because you don't know. That's not your area.

A. Uh-huh.

Q. Correct?

A. That's what I answered before. In other words, I answered that actually several times. Again, that's not my area of expertise. If

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you want ... details on how a study is conducted and looking at the validity and all of that, you probably need to go to a statistician. That's not an area that I would feel comfortable responding in.

Q. For example, the width of the confidence interval, if any, within which this estimate is made is not your area?

A. Again, no. I was not there. I didn't do it. That's not my area.

Q. Are you an economist?

A. No. I'm not a economist.

Q. Have you ever attempted yourself to calculate the economic burden of any particular risk factor?

A. No, I have not.

Q. Calculating the economic burden attributable to any particular risk factor is not something that's within the scope of your expertise. You have never done it; right?

A. It depends on -- What are you referring to in my document? Could I see which one

you are talking about?
Q. I'm asking you a general question,

Doctor. Would you please answer it?
A. I would like to see what you are referring to. It would be -- you are referring to --
MR. GOLDBERG: Page two of your --
THE DEPONENT: Two.
A. Okay. Yeah, okay.
Q. My question did not refer to anything, explicitly to anything in your report.
Could you answer the question, please?
A. Why were you reading out of it, or looking at it when you responded, or asked the question.
MR. GOLDBERG: Read the question back. Let's see what the question was.
REPORTER: "Calculating the economic burden attributable to any particular risk factor is not something that's within the scope of your expertise. You have never done it; right?"
MR. GOLDBERG: Compound question. Object to form.
MR. ROWLEY: Let me rephrase it.
Q. Calculating the economic burden associated with any particular risk factor is

something that you have never done in your entire career; right?
A. Typically, no, I'm not an economist, and I would not, in fact, do that. But in terms of what it cost, I think you were referring as you were reading in the report -- you said you were not looking at it, and you are looking at it again -- is the economic cost of smoking and the national.
And you can see that reference in particular. And those numbers that I'm quoting are specifically, if someone were to ask me what are the economic costs of smoking, basically, what I would do is I would go back to reference 11 here. And you can see that, again, it's the Centers for Disease Control and Prevention.
Basically, what I have tried to do in this report is consistently stick with one organization, and that's the Centers for Disease Control. Centers for Disease Control, in fact, identified what a smoker was. They have identified how many people have died as a result of smoking.
And now we are talking in terms of economic costs, you can see that it's also from the Centers for Disease Control.

So, again, I don't go in and quote and check those numbers or whatever. Once those are reported, I assume those to be correct.
I'm not an economist. I have not gone in there and, in fact, looked at those numbers, checked to see how they have done that. I don't have that time.
If someone reports, I mean, any number out there, in the literature, when it is refereed, then I would do that.

What I have tried to do is remain consistent with CDC, tried to quote or use as much of their information. I don't do those studies.

Q. Do you remember the question that I asked you?

A. Yes.

Q. What was the question?

A. The question was whether I had ever done economic calculations.

Q. I appreciate that response. Can you now tell me whether you ever have?

A. To a certain degree. I mean, we are talking relatively simple. There are levels, if someone were to say, in terms of economic cost,

that it costs one million as a result of smoking-related disease, and there were, or in terms of a company and there were one million people that worked there, I could say it was one dollar per person. That's a simple as you can get it, and there's nothing particularly complicated about that. Just like if I ask you miles per gallon, you'd have to know how many miles you drove and the gallons, and you just divide one into the other. And it's real simple to get a general number.

So something that simple I could have done. Now, I don't do complicated economic costs and so forth, because I'm not an economist. But I can do something relatively simple. That's real easy.

MR. GOLDBERG: Counsel, I'm sure this witness would stipulate, and we would as well, that he did not do the economic calculations that are discussed in his report, but rather reported those from reputable scientific journals. But he did not do those calculations himself.

MR. ROWLEY: Thank you for stipulating to that. I wasn't under the impression that he

had. But I appreciate the stipulation.

Q. Doctor, would I be correct in saying that you're not familiar with the scientific methodology that was employed in reaching any of the estimates under the heading Estimated Costs of Smoking --

A. That's correct. And just to save --

Q. You're -- Go ahead.

A. And just to save time, as was said, I did not calculate, I did not participate, I did not know how these numbers were arrived at. I'm not an economist, and it's not happened. Hopefully, that will save a lot of time, rather than you repeat and repeat and repeat and go over.

Q. You're not an expert in the methodology, and you're not an expert in assessing whether the methodology was correct?

A. That's correct.

Q. And you haven't, in fact, assessed whether any of these estimates are correct or not; you are simply repeating them from a reference?

A. Correct.

I think, just following up when I said

that is correct, if you really stop and look,

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you're sort of asserting that I should have done all of these other numbers in terms of the number of deaths in the U.S., that I should have done or looked at all that data and looked at how all of these economic costs and this data were collected and so forth. That's just not simply within the scope that someone would do.

When someone writes a little intro to a paragraph or works, you basically quote some of the numbers. And you try to use the most reputable numbers that you possibly can. And, again, I have been consistent using CDC because that's where I believe that the numbers are very consistent. And I'm trying to use the same thing or the same reference most of the time.

Q. Let me ask you this. These dollar figures under this heading, are these your opinions or are these the opinions of an expert that you are repeating in your report?

MR. GOLDBERG: Object to form. Vague.

Q. Go ahead.

A. I think that was answered. I told you that, basically, I get a reference, and I would go and get it. I have repeated that I have answered

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that question, actually, at least once.

Those are numbers that, basically, were collected by CDC. I can't tell you the methodology. I can't tell you how they did it. I can't tell you how they arrived at the numbers. I am not an economist. That's not what I do. And those are the numbers that are reported, and those are the numbers that I have, in fact, looked in their report and they noted that.

I don't go back and double-check and see if, in fact, those are correct. That's not what I do. That's what peer-review journals do. That's what -- Again, other people have made that determination. I simply don't do that.

Q. Are there people, Doctor, who could, if they were to testify in this case, tell us what the methodology that was employed in reaching these estimates was?

A. I'm sure if you went to CDC and asked them how they arrived at these numbers and so forth, I am sure they would, you know, they would discuss it. I just never had a real need to.

Again, I think that's much more time than I need to spend on actually going and see how

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they calculated and double-checking all of these billions of dollars and seeing if, in fact, this is correct, or millions. Millions and billions of dollars here. I just don't go in and look at hospital care. Someone else does that.

MR. GOLDBERG: Counsel, maybe my stipulation, and, I think, what the witness would stipulate to was not clear.

But with reference to the section of his report, Economic Costs of Smoking and Impact of Smoking on Productivity National, I believe that

this witness and that Plaintiffs would also stipulate that these figures that he has reported are from studies of others and that he is not testifying to the method, he will not testify as to the methodology or any aspect of the procedure undertaken to arrive at these figures, merely he will report these as being reports from reputable and widely-regarded journals on this topic.

I don't know why with that stipulation we have to continue this. If you want to, you can. But I don't know what else you would expect in the way of a stipulation. Is that satisfactory?

THE DEPONENT: Yes. I mean, I'm not

an economist. I've made this clear so many different times or whatever. But I just see that it's consistent and constant badgering and asking the same things over and over.

MR. GOLDBERG: But you are comfortable with the stipulation that I --

THE DEPONENT: Yes, I think so. I'm not an economist. Basically, these numbers, it's very clear that I didn't do this work or whatever. If someone would ask me about the economic costs or whatever, I would go in and look at them and report them.

MR. GOLDBERG: I don't have -- I mean, you can keep asking questions, but --

MR. ROWLEY: I appreciate the stipulation, and it is certainly in the record, and you are most certainly bound by it. And thank you for stating it on the record.

Will you stipulate that he does not have the expertise to assess whether any of these calculations are, in fact, scientifically valid, or do I need to ask him those questions?

MR. GOLDBERG: I will stipulate, subject to the witness confirming, I think he will,

that he does not have the expertise to evaluate the calculation.

However, I believe that the Court will rule that he has the expertise to offer testimony as to what the reports say. He will not, which is different than testifying to the methodology of how they are done and whether it is valid or not.

MR. ROWLEY: Is that stipulation acceptable to you, Dr. Glover?

THE DEPONENT: I think --

MR. GOLDBERG: Did you understand what I said?

THE DEPONENT: Yeah, that was rather long. Actually, I think, yeah, I would agree with that.

MR. ROWLEY: Will you stipulate that he is unable to testify and does not have the expertise to evaluate the probability that any of these calculations are correct or incorrect scientifically?

MR. GOLDBERG: We are referencing the Economic Costs of Smoking and the Impact of Smoking on Productivity?

MR. ROWLEY: Introduction on page 1,

The Economic Costs of Smoking National on page two, The Impact of Smoking on Productivity National on page 2 as well.

THE DEPONENT: On page 2, you said The Impact of Smoking? Is that what it was?

MR. ROWLEY: Yes. Is that stipulation satisfactory to you, Doctor?

MR. GOLDBERG: We're not stipulating that he won't be able to testify as an expert and give these statistics. But we are stipulating that he won't testify as an expert as to the methodology or validity of the statistics, other than his view that because they are in the widely-disseminated and reputable journals that he believes that are valid.

MR. ROWLEY: So you will stipulate that he does not have the expertise to evaluate, and, in fact, has not evaluated whether any of these estimates are, in fact, scientifically correct? Is that right?

MR. GOLDBERG: Other than his evaluation of the literature generally, but not the calculations.

MR. ROWLEY: Not the conclusions that

he cites? He has not evaluated the scientific validity of the statements and assertions contained in the report?

THE DEPONENT: I don't want to --

MR. GOLDBERG: This is not productive. It's only going to save time if we don't sit and discuss it. If you're not willing to agree, you are not willing to agree.

MR. GOLDBERG: I am willing to agree to what I stated, but you apparently didn't think it was clear.

MR. ROWLEY: No. What you stated was clear, and you are certainly bound by that. I acknowledge that you are bound by that.

BY MR. ROWLEY:

Q. Doctor, suffice it to say that you have not attempted to independently verify scientifically whether any of the conclusions on pages 1 and 2 of Exhibit 1 are scientifically correct; is that fair?

A. That's fair, as I have answered that. You keep saying that I am wasting time, and I have answered that question several times. And I wasn't a while ago, and I'm still not.

Q. If you look on page 3, you have a list of diseases that are, that you assert are associated with smoking. We established yesterday, of course, that you're not an expert in disease causation.

A. Correct.

Q. Did that testimony, do all of the diseases that are listed on page 3 -- Let me rephrase.

You are not competent to assess the issue of causation, medical causation, with respect to any of the diseases or conditions listed on page

3 of Exhibit 1. Is that true?
MR. GOLDBERG: Objection, vague.
Q. Is that true?
A. I would think that that's, that's probably true.
Q. Thank you, sir.
And that's true with respect to the diseases and conditions reflected on page 4 of your report as well?
A. In terms of causation?
Q. Yes, sir.
A. Again, I don't go in and do the very

particulars. I can generally tell you, say something relative to lung cancer. I can't report how the actual mechanism of the disease occurs and what happens.
I can tell you that typically, just as a general rule, most people will say that for every pack an individual smokes the chances of getting lung cancer are 10 times greater. So they talk about an association. Or 20 times greater at two packs or whatever.
So we do know that some of these are caused, and that's why that's in the report.
I'm not a physician. I don't go in and work with COPD at, the asthma, the lung cancer, the respiratory infections. I'm not an oncologist or whatever.
But, again, just as with the previous, I don't go in and do that research. That's not what I do. Basically, what I'm doing is reporting what's in the literature, what has basically been accepted as fact. And that's what I reported.
Q. The scientific question as to whether smoking causes lung cancer is an epidemiologic and medical question; right?

A. That's correct, probably.
Q. And that question is beyond the scope of your expertise?
A. Again, I don't do that kind of research. That's not what I do. But once that's reported in the literature and widely spread and widely held that, in fact, cigarette does, in fact, cause lung cancer, then I can report that. That's basically what I'm reporting.
I did not do the lung cancer research or any of this type of cancer research, lung cancer, kidney, pancreatic, bladder. I didn't do any of this. Basically, it's been done by physicians and epidemiologists and other researchers, statisticians and a whole variety of individuals that, in fact, this data have been collected and reported, and basically I'm reporting what they have published.
Q. The question of what causal criteria were used is not something that's within the scope of your expertise?
A. That's not what I do. That's correct.
Q. The question of whether the correct causal criteria were used in reaching the

conclusions on pages 3, 4, 5, 6, 7, 8 and 9 of your report is not something that's within the scope of your expertise?

A. I got lost once you got to the pages. I got the pages. Repeat the first part of the question. Once I started looking I was actually reading as well.

Q. The question as to whether the causal criteria that were used in reaching the conclusions with respect to any disease or condition that's referenced in Exhibit 1 is beyond the scope of your expertise?

A. Again, I'm not a physician, and that's not what I do. I'm not an epidemiologist. I'm not a statistician. Typically, that's not what I do. My expertise is in a different area. I just need to know, I need bits and pieces of that information to do the work that I do.

And I think it is widely held by virtually everyone, that tobacco, in fact, does cause cancer, or some of these other problems.

Q. The empirical probability that that conclusion is correct is not something that's within the scope your expertise?

A. All you need to do is look at the research that's out there. Then you will, in fact, see that upwards of 90 percent possibly, and I couldn't tell you exactly what number or whatever, but the majority of the people will, in fact, come to that conclusion, because of the cancer-causing agents found in cigarettes and so forth.

And, again, that's not something that I do or whatever. But once it is reported and people quote numbers or whatever, and that is changing slightly from year to year, whatever.

But, in fact, when I am on a report whether I'm talking about all of these variety of cancers or heart disease or whatever, I don't want go back and do every one of these studies. I don't go back and double-check every bit of this data. You would never, ever in your lifetime complete one article.

There are certain things that are in the literature, the refereed literature, that, in fact, are accepted as fact. And I think that's one of the, tobacco or cigarettes causing cancer is, I think, probably one of the strongest ones out there. I think that very few people that, in fact,

would disagree with that.

MR. ROWLEY: Counsel, so I can decide whether to continue with this or move on, will you stipulate that this man is not an expert in the field of disease causation?

MR. GOLDBERG: Go off the record for a minute rather than debating it on the record.

MR. ROWLEY: Yeah. Let's go off.

(Off the record.)

VIDEOGRAPHER: We are now back on the record.

MR. GOLDBERG: Counsel, Plaintiffs are prepared to stipulate, subject to the Doctor's

approval -- so listen carefully to what I'm saying -- that we will stipulate that you are not an expert in assessing the disease causation described in pages 3 through --

THE DEPONENT: It's 9, I believe.

MR. GOLDBERG: -- 9 of your May 25 report, in the sense that you do not do that research and cannot assess the validity of that research. However, it is my belief that the Court will view you as an expert who can give testimony reporting the research based on your field of work.

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MR. ROWLEY: Okay. And I will --

MR. GOLDBERG: If you accept that, that will save us a lot of time.

MR. ROWLEY: I will accept the stipulation part of it. I do disagree with the admissibility.

MR. GOLDBERG: You can argue that he is not an expert reporting what these studies.

MR. ROWLEY: I will just state that, in our view, an appropriate expert to testify about scientific matters must be in a position to assess or verify the scientific validity of the opinions that he reports. But we need not resolve that now.

MR. GOLDBERG: Okay.

MR. ROWLEY: Thank you.

MR. GOLDBERG: Is that satisfactory?

THE DEPONENT: Yes.

MR. GOLDBERG: Did you understand what we were saying?

THE DEPONENT: Yeah. That's close.

Q. Doctor, how do cognitive factors differ from behavioral --

MR. GOLDBERG: By the way, if we are going to a new area --

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MR. ROWLEY: Break any time you want.

MR. GOLDBERG: Sounds like we are going into a new area. So let's take a brief recess.

(Break.)

MR. GOLDBERG: The stipulation that the Plaintiffs made Doctor Glover agreed to with respect to certain sections of the May 25, 1999, report, also applies to page 1, the second and third paragraph of page 1 of the September 3, 1999, report.

MR. ROWLEY: And Lorillard Tobacco Company acknowledges that you are bound by that. Thank you.

BY MR. ROWLEY:

Q. Doctor, look at page 9 of Exhibit 1, please.

A. All right. Do you want me to read it or just to look at it?

Q. No. I want you to look at it. Look at the first sentence in the last paragraph.

A. All right.

Q. Read that sentence for us, would you.

A. For many years there was a debate

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whether nicotine --

Q. I'm sorry, Doctor. The first sentence of the last paragraph. It begins with, As recently.
A. Oh, oh, oh. I got you. Just one sentence?
Q. Yes, sir.
A. As recently as 12 to 15 years ago we discovered that the brain had nicotine receptor sites.
Q. Is there a footnote or reference cited for that assertion?
A. That was -- no, there is not.
Q. Did the plaintiffs lawyer tell you that it would be important for you to confirm the accuracy of statements that are contained in these reports?
A. I don't remember, but I'm sure they would have expected it.
Q. What was your source for this assertion?
A. Being a member of the Society for Research in Nicotine and Tobacco, I have listened to many discussions relative to Dopamine and so

forth, and being able to discern or being able to draw from what my level of knowledge is, basically, in talking to Balfour from Scotland and some of the individuals, they said that the concept of nicotine receptor sites in the brain was relatively a new concept, and it was 12 or 15 years ago when it was first actually discovered.
Q. Who did you say told you that?
A. Balfour from Scotland. He's one of the people -- B-a-l-f-o-u-r -- in participating in the Society for Research in Nicotine and Tobacco. In a conference, I can think of one in particular, a conference that was held in Bethesda at the CDC NIH, and that was discussed as well there thoroughly. I think that same conclusion. So I could very easily go back and put in both of those references to those, because that's where that information came from.
Q. Is this statement, and by this statement I mean, "As recently as 12 to 15 years ago we discovered that the brain had nicotine receptor sites," is that statement indicative of the accuracy of the remaining statements in your report?

MR. GOLDBERG: Objection. That's an inappropriate question.
Q. Go ahead, Doctor.
MR. GOLDBERG: Vague.
A. No. I think they are all accurate. I don't reference every sentence and every bit of information that's said. If I were to say the sun rises and sun sets, I wouldn't reference that. I think there are certain things that are known, and I think that's one of those that researchers in the area are beginning to realize, that the brain has nicotine receptor sites. There's nothing, I mean, people are beginning to write that, discuss that and so forth. It's very much like I said, if the

sun rises or sets, I don't reference that sentence. If you would like me to, I can get you those reference. It would be real easy, and that would take care of the question.

But that, in fact, is accurate, to the best of my knowledge, and the other information as well. Most of that, in fact, has been gleaned from various literature. I don't do that type of research. That's probably Jack Henningfield. That's probably Neil Benowitz. There's others

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that, in fact, do that.

But my knowledge and what I need, and when I do treatment I have to have a general understanding. But I'm not an expert in those areas. That's a secondary expertise. My area is actually in the treatment.

Q. So the question of when nicotine receptors in the brain were first discovered is not your area?

A. No. That information is, I don't do that type of research. I'm not a psychopharmacologist. I don't deal in that biobehavioral health area. I don't do that.

Q. You did nothing to confirm that the statement that we are discussing is correct, that is to say, you didn't go back in the literature to see when references to nicotine receptors in the brain first appeared in the literature?

A. Again, I can tell you that, in some conversation with Balfour from Scotland, I think I had a couple with him, and I can tell you that it was at CDC, so those are the people that actually wrote it. So I went pretty much to the source. So I think that that's a, I would venture to say that

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that's pretty accurate.

Q. You are sure about that?

A. Yes.

Q. So this is a statement in your report that it was 12 to 15 years ago that it was discovered that the brain had nicotine receptor sites, and that's a statement that we can rely on; right?

A. I'm pretty sure that you could. Again, unless I may have misunderstood him in some way, in my discussion with Balfour from Scotland, at the Bethesda Conference on Nicotine Addiction, I feel, with a great amount of certainty, that, in fact, is correct.

I'm not the person that did that, so I couldn't tell you that I discovered it or I did that. I am not a psychopharmacologist. But I feel relatively confident that that statement is, in fact, true.

Q. Is it true, Doctor Glover, to a reasonable degree of scientific certainty, that it was 12 to 15 years ago that it was discovered that the brain had nicotine receptor sites?

A. It's my understanding that 12 to 15

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years ago, it's probably, that's when it began to discover, began to be reported. I think I might be

a year off, you know, say, No, it was 11 years and 13, or 11 months or whatever. So, I mean, I can tell you, and that's why I put a little range in there. It's somewhere in there. That's basically in talking to them and in conversation, in casual conversation, they said 12, 15 years ago, somewhere in that vicinity.

Q. You're confident about that, aren't you?

A. Uh-huh. What's that?

Q. That that statement that it was 12 to 15 years ago that it was discovered that the brain had nicotine receptor sites is accurate?

A. Again, to the best of my knowledge, unless I misunderstood both places or whatever. If you would like, I think relatively easy, I can get a reference for you. It would save us a lot of time. In other words, I mean, that's the best of my knowledge. I don't, that's not the research that I do. That's not where I go with this.

And I'm basically reporting what was, in fact, mentioned by Balfour at Bethesda. And I

actually even have the booklet that was handed out at Bethesda. I'd have to go back there and look. It could have been a typo here or something, or whatever, but I feel relatively sure that I can go back and, in fact, get that for you. And I will do that.

Q. Was that a peer-reviewed publication?

A. The one --

Q. Either one.

A. Either one. One was in conversation with Balfour in Scotland, because that's not the literature that I typically read, even though, again, it's presented at various meetings. I think I have heard it, as I mentioned a while ago, at the Society for Research for in Nicotine and Tobacco. Then when it was presented in Bethesda, that was, I don't believe that was a peer -- no, it was not a peer-reviewed publication. I think they brought in experts from all over the world to talk about nicotine addiction. I need to go back, and I'll actually double-check that for my own benefit.

Q. So you believe that this statement is it true for the same reason, same reasons that you believe the other statements in your reports are

true, and that is that you got it from what you consider to be a reliable source? Is that fair?

A. To a certain degree. But I think the point that you made earlier in the sense that, I think, the other references and so forth specifically came from refereed journals. And I can, in fact, say that I feel incredibly confident with those.

This one in particular, because I didn't reference it, I would have to go back and double-check just to make sure. But I feel, I feel confident. I could be in error, but that one in particular was not referenced. I did not read that in a refereed journal as much as talking to the source and attending actually The Society for

Research in Nicotine and Tobacco, and actually in discussions that were carried on in Bethesda in a big nicotine conference. And I may have misunderstood them or something, but that's the best of my knowledge. I would have to go back and just double-check.

So that one, I would venture to say, I did not pull it out of a journal; therefore, it is not refereed. But everything else previous to that

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is refereed in the sense that it was all, you know, you see the numbers and the quotes and so forth.

Q. Is the MMWR refereed?

A. Yes.

Q. It is?

A. Uh-huh.

Q. How do you know that?

A. Because when we submit manuscripts they do get rejected, and someone is rejecting them.

Q. Simply, you can write a letter to Time magazine and that can be get rejected. That doesn't mean that Time magazine is refereed.

Do you have any basis aside from the fact that you have had manuscripts rejected from MMWR that it is refereed?

A. Typically what happens, again, you have to submit manuscripts and they are refereed. And I would venture to say that I can't tell you for sure, positively, beyond a shadow of a doubt, but I feel very, very confident that that, in fact, is refereed. I would have to go back and, again, double-check. But I would feel very confident that it is refereed.

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Q. Are the various CDC publications that you cite, the ones that have DHHS publication numbers, refereed?

A. Refereed, yes, in the sense if you look real closely at the Surgeon General's report, they may write those, and you will see typically they will have 50 consultants. I've served as consultant to various chapters and various reports. But they will send it to 8, 10, 20, 50 people.

So in a classic sense, what happens is people are really asked to write a report, and they write a report and it's sent out to 20, 25, 50 experts. And in some ways publications like those are, in fact, may be even more refereed in the sense that it goes through more experts taking a look and reviewing those than a typical journal. A typical journal like JAMA, New Englan Journal of Medicine, you're talking three to five people. Some of these others go through major extensive revisions, and they look at it, because they want to be as accurate as possible. It may go through 15, 25 people to actually look at it that it's being sent out to.

Q. Bearing in mind, Doctor, that you told

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us yesterday that you didn't know what a nicotine receptor was, can you tell us of what significance this sentence that contains the phrase "nicotine

receptor" is in this lawsuit?
A. Actually, in keeping in mind that the answer that I gave you is that I was basically not a neuropharmacologist, in other words, I don't know how they develop, what actually, when developed, in other words, I don't know a lot of the specifics. What I need to know, I am a treatment specialist, and basically here is basically what I do. I have overlapping circles of a little secondary knowledge of some of this. I need the knowledge for my work. I don't go in and do psychopharmacology work. That's simply not what I do.

That statement or whatever, in fact, talking about nicotine receptor sites in the brain, you can see if you follow it very closely with the subsequent one. This is, I remember, sitting in, I think it was Helsing?r, Sweden, or Copenhagen where I actually asked Balfour specifically about the density. He basically said, if you follow the second sentence rather than pulling that one sentence and spending 30 minutes on it,

subsequently in there he said, We discovered that the greater exposure to nicotine, the more you smoke, in other words, basically what he is saying there is that greater density of nicotine receptor sites in the brain are developed as a result of smoking.

He said he had done, he had looked at port-mortem and he had discussed it, and it's been presented in meetings and so forth.

I mean, to me, that's information, and that just tells me that for me for treatment that may, in fact, may be beneficial.

No, I don't go in and do that type of work, and that's not what I do. But I just have a general understanding of what a nicotine receptor site is. That's all I need to know. I don't need to go into specifics.

Q. This is the same Balfour who told you that it was 12 to 15 years ago that it was discovered --

A. Again, as far as --

Q. Excuse me, Doctor. May I please finish the question?

This is the same Balfour who told you

that it was 12 to 15 years ago that it was discovered that the brain had nicotine receptor sites?

A. In my discussions with him and so forth, I may have misunderstood that number or whatever. But I think in talking with him and the Society for Research in Nicotine and Tobacco, and at the Bethesda, Maryland, and I'm not sure whether I heard it at all three or two out of three or one of the three, but those are the places that I have talked with him about it.

I have heard some of the nicotine receptor site work being talked about, the Society for Research in Nicotine and Tobacco, and I have done it at Bethesda. I know that they have talked about it. And I can't remember in all of these

conferences that I have attended where in particular I got one sentence out of one paper. But I can tell you that it was one of those three places.

MR. ROWLEY: I will move to strike that.

Q. Can you just tell me whether it was the same Balfour, because that's what I asked?

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A. I just responded to that. I don't know what else you want. I told you that I don't know whether he told me. I will repeat this again for you.

Q. Thank you.

A. I don't know whether he told me. I don't know whether I got it at one of the other places. I answer these questions. Evidently you don't listen well.

Q. It is just hard to, on those rare occasions where you do answer the question, it is hard to pick it out of all the rest of the things you say.

MR. GOLDBERG: Objection, move to strike counsel's comments.

Q. So you don't know where you got that assertion?

A. I can narrow it down to three places. I can tell you that I got it from Balfour sitting in Helsing?r or Copenhagen, or I got it at the Society for Research in Nicotine and Tobacco, or I got it from the Bethesda conference. I told you repeatedly where it came, one of those three places, or possibly all three.

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Q. Did you go back to the literature of the 1930s to see whether nicotine receptors in the brain are referenced in that literature?

A. No, I did not.

Q. Did you go back to the literature in the 1940s to see --

A. No, I did not.

Q. Can you please wait until I finish with the question.

Did you go back to the literature of the 1940s or the fifties or the sixties or the seventies to see whether, in fact, nicotine receptors in the brain are referenced in that literature?

A. No. I did not.

Q. Therefore, you don't know whether nicotine receptors in the brain are referenced in the scientific literature in the thirties, forties, fifties, sixties or seventies; correct?

A. What, the nicotine receptor sites?

Q. Yes, sir.

A. No. I do not.

Q. You just got done saying that you have a general understanding of what a nicotine receptor

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site is. What is your general understanding?

A. I know that, basically all I need to know. I don't need to go into great depth and so forth. All I need to know to help people to quit

smoking is to know that, basically, in these nicotine receptor sites, is the more you smoke the greater density of nicotine receptor sites you will develop and the more difficult it becomes to smoke. That's what I need to do to practice my expertise, which is the diagnosis of the addiction and actually treating the individual.

I don't need to go all in the psychopharmacology. I don't need to work at that cellular level to have a general understanding of what it is. And that's where I, that's all I need to know to be able to treat people.

Q. Is this hypothesis regarding the density of nicotine receptor sites controversial?

A. No. I don't, I don't believe so. As I think about it, in my discussions and what has been mentioned, I think I have heard it sufficiently. Maybe I haven't heard other people saying, no, that they don't develop. But I do know that at least the common thinking among the

researchers that I respect, which are people that would be presenting at these places, if, in fact, that's what they are reflecting and that's what they are thinking. So I have respect for them, so I'm assuming that they, in fact, are correct, because that's not what I do.

Q. Did you review the literature to see whether and, if so, how many scientists say that this hypothesis regarding density of nicotine receptors is incorrect?

A. No. I did not.

Q. How did you quit smoking?

A. Huh?

Q. How did you quit smoking?

A. How did I quit smoking?

Q. How?

A. Did I quit smoking?

Q. How did you quit smoking?

A. What I tried to do is, I was always telling individuals that I could quit anytime I wanted to, probably practicing a little self-deception. And the bottom line is I was left without cigarettes one time, and I found that I began to experience withdrawal. And I had a real

difficult time quitting. And I realized that I was basically experiencing withdrawal and was getting hooked on cigarettes. So what I did, because I had only been smoking a year or two, not very long, I made a real effort and did everything I could to quit possibly. And I, in fact, quit.

Q. How old were you when you did that?

A. 18, 20, somewhere. I just can't remember. It's quite a few years back.

Q. Did you ever pick up a cigarette after that again?

A. No.

Q. After you quit?

A. No. I'm trying to think here. Well, I don't, I'm trying to think. I don't know. I may have at a party or something, someone handed me one or something. But I can't, I don't remember. I

mean, I never started smoking, full-blown smoking again.
Q. You were never a regular smoker again after that?
A. No. I have not smoked a hundred cigarettes or more since that time, I can assure you. You know, the definition that you were trying

to provide yesterday.
Q. You haven't smoked a hundred cigarettes or more since you quit smoking? Is that what you're saying?
A. Correct.
Q. That period of time right before you quit, was that the first time that you realized that you were having withdrawal symptoms?
A. Correct.
Q. Was that the first time that you suspected that you might be becoming, I think you said, hooked? Was that the first time you realized that?
A. Yes. Up until that point I was always saying that I could quit on my own. And I was left without cigarettes. Actually, I had cigarettes in my hand. I happened to be on an island, a remote island. We were surfing, because I was still a young person then. And my cigarettes fell in the water and I was without matches, but I had cigarettes.
And when I began to try to rub sticks together and rocks together to try to get a fire to light a cigarette, and then after a while I began

to chew on the cigarettes, I realized that I was only practicing self-deception, that, in fact, I was a little more hooked or addicted or dependent on the cigarettes than I thought. So that frightened me, because I liked being in control, and I was not.
Q. Up until that minute you believed that you could quit anytime and that you weren't hooked?
A. Yes, possibly. I think so. I think I thought that, for me in particular, I was special and that I was not addicted to cigarettes.
Q. Obviously, you had never tried to quit before, or you would have known?
A. Correct.
Q. Of what significance is it, if it is, in fact, true, that the density of nicotine receptors increase? Of what significance is that?
MR. GOLDBERG: Object to the form.
Q. Go ahead.
MR. GOLDBERG: Increase?
MR. ROWLEY: Density of nicotine receptors.
Q. Of what significance is that?
A. Again, as I mentioned in the

statement, and it's my understanding, in terms of that's not my expertise and that's not my area, I have just limited knowledge to do what I do. I can't be an expert in all of these areas.
It's my general understanding that the

more an individual smokes the greater density of nicotine receptor sites are developed the brain. I think I have mentioned that in here.

Moreover, not only the more they smoke, but the longer they smoke the greater density.

What does that mean? That just means greater density. In my opinion, from what I gleaned and what limited knowledge I have is that it becomes a little more difficult for that individual to quit.

Q. So it is your understanding that the higher the density of receptors the more difficult it is for somebody to quit smoking?

A. That is correct.

Q. Is there a scientific study that even hints that that's true?

A. Again, what we needed, I can show you a lot of the actual publications, some of the work

that, in fact, is done. You can put this in your notes and look up some of London's work and Balfour's work. I think they mentioned those. I don't have the references readily at hand. And I didn't evaluate their skills and what they did. But they, in fact, show brain scans and so forth where you actual look at. They will show people that are smoking and not smoking.

Again, it's the more you smoke, as I said, the more you smoke and the longer you smoke, the greater density, the more that individual will, in fact, smoke. And, obviously, it becomes a little more difficult for them to quit.

I only need limited knowledge in that area, because when we are treating the individuals we know that if someone has been smoking longer it is going to be more difficult for them to quit, as opposed to them only been smoking for a shorter period of time.

So we try to -- That, again, is just one of the many tools that we have. If someone has been smoking 40 years, we know that, in our opinion, in my professional judgment, in working for 25 years in cessation, that they are probably

going to have -- and I'm generalizing here. This is one of many tools -- they're probably going to have a little more difficult time than someone who has only been smoking a short period of time.

Q. Are you finished?

A. Yes.

Q. What's the strength of the association between the density of nicotine receptors and a person's difficulty in quitting smoking?

A. Again, the -- Association in what way? What do you mean? What do you want, a number?

Q. Has that association been demonstrated empirically?

A. In terms of actual quitting?

Q. Has the presence of that association, that is to say, whether there is such a statistical association, been demonstrated empirically?

A. Again, what we do, we need to make

this very clear, what we have done is to experience over time, we generally find if what they are saying is, in fact, true, in terms of greater density of nicotine receptor sites, and we are finding that the longer a person is smoking and the more that they may be smoking that it becomes more

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difficult, there might be an association out there I don't know.

That's not the kind of research that I look at. And, again, I am limited in what I need to be able to use to help people quit smoking.

My approach is not to get involved in the scientific validity or to get into psychopharmacology or epidemiology, or to get into statistics or whatever. My job is to try to help people quit smoking. We do the best that we can, and we draw from whatever we can whatever we need.

Q. Does sugar have psychoactive effects?

A. I'm not a sugar expert.

Q. Do you know whether sugar has psychoactive effects?

A. I'm not a sugar expert. I wouldn't -- That's not my area of expertise. I have no idea. I am not into nutrition. That's not what I do.

Q. Does that mean that you don't know whether sugar has psychoactive effects?

A. No. That means that I'm not an expert in that area, and I don't know, breaking down sugar in the chemical compounds or the actual individual chemicals that are there and whatever. That's not

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what I do. I don't get into sugar. I mean, that's not, that's nutrition. That's simply not what I do.

What we do is we diagnose people that are on nicotine dependence, and we try to treat the nicotine-dependent patient. That's what we do. We don't get into nutrition. I'm not a nutrition expert.

Q. Do you know whether sugar has psychoactive effects?

A. Again, I am not a nutrition expert.

Q. Does that mean that you don't know whether sugar has psychoactive effects?

A. I'm not a nutrition expert. That's not something I do.

Q. Do you know whether sugar has psychoactive effects?

A. I'm not an expert. I mean, that's not something I do. I mean, it may. It may not. But that's not something --

Q. You don't know. It is okay to say you don't know.

A. It's not something that I do, so I don't really, you know --

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MR. ROWLEY: Counsel, will you tell the witness that it's okay for him to say he doesn't know, especially if he has no involvement, if there's no reason for him to know. It's fine. It's perfectly acceptable.

MR. GOLDBERG: Off the record for a

minute, please.
(Off the record.)
VIDEOGRAPHER: We are now back on the record.
BY MR. ROWLEY:
Q. Doctor, I know you just chatted with the Plaintiffs' lawyer.
As a result of that conversation or not, will you now tell me whether or not you know if sugar has psychoactive effects?
A. My position is such that virtually everything that you intake, whether it's milk, food or anything, everything has some kind of effect on the body. And they can have, obviously, if you are starving or whatever, it can have some psychoactive effects.
So virtually any chemical, any compound that you take in, virtually -- I can't

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name everyone of them or whatever -- and that would include sugar, have some psychoactive properties. I mean, not psychoactives in the sense of hallucination or whatever, but it does cause a chemical change in the brain that may, in fact, show that glucose is there.
Q. Does exercise have psychoactive effects?
A. Rather than to go through all of these and have to explain every one, yes, exercise has psychoactive effects.
Q. Thank you.
Does caffeine have central nervous system effects?
A. Yes.
Q. Does chocolate have central nervous system effects?
A. Yes.
Q. Does sugar have EEG effects?
A. I probably couldn't answer that with a certain degree of certainty. I don't know.
Q. Thank you.
Does caffeine have EEG effects?
A. Yes.

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Q. Did carbon dioxide have EEG effects?
A. Again, just to make it clear, for all practical purposes, I'm not a pharmacologist. That's not what I do. I have limited knowledge on that. And, basically, the knowledge that I have, and you could go through a million compounds or whatever, but I have limited knowledge on those. And it would be, that has nothing to do with, or very little to do, certain aspects of it have some to do with what we do in terms of actually treating the nicotine-dependent patient.
Q. I just want to know if you know --
A. Sure.
Q. -- if you know, what you're answer is, and if you don't know I want you to say that.
Does music have EEG effects?
A. Yes.
Q. Does sleep deprivation have EEG effects?

A. Yes.
Q. How about exercise?
A. Yes.
Q. Is food reinforcing?
A. Yes. Can be for some.

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Q. Is sex reinforcing?
A. Yes. For some.
Q. How about water, has that been shown to be reinforcing?
A. Yes. It's a necessity of life. Hopefully, that it is reinforcing. It's a necessity of life and everyone has needs.
Q. In fact, all the necessities of life are reinforcing?
A. Yes.
Q. In fact, virtually every enjoyable activity is reinforcing?
A. Correct. Virtually every, I mean, I think that's a pretty sound statement.
Q. What substances produce Dopamine in the brain and cause its release?
A. I couldn't name them all, but I can --
Q. Can you name any of them?
A. Sure.
Q. Go ahead.
A. Virtually, I mean, you could start off with nicotine. That's all that I care about, and that's all that I work --
Q. There's one.

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A. But that's the one that's important to me, and that's the one that I work with.
Q. Can you name others?
A. You could drink milk and that can give Dopamine levels, that can elevate them.
Q. Can you name others?
A. I mean, exercise, sex. There are Dopamine, you can have caffeine. You can have a variety of things. Everything can have, I mean, that is, virtually everything that you can intake can have some effect on Dopamine levels. So --
Q. How about -- I'm sorry. How about watching TV, can that --
A. Yes. Sure.
Q. Watching TV can cause the production and release of Dopamine within the brain?
A. Correct. It can. In some individuals, I'm sure.
Q. Are there receptor cells in the brain that are associated with Dopamine release that is caused by exercise?
A. Receptors in the brain that do what now?
Q. Are there receptors in the brain that

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are associated with Dopamine release that is caused by exercise?
A. By exercise. I guess I'm not quite sure of -- I can give you a general idea of how they work or something, but I'm not really quite sure what you are asking, to be really honest. I'm being honest this time. I'm not sure what you are

asking.
Q. I certainly appreciate that.
Has, Doctor, nicotine been found to be a major contributor to cigarette flavor acceptability?
A. I don't -- That's not the kind of research that I do or read. In other words, I'm not really quite sure what you mean flavor.
Q. Acceptability, the acceptability of the flavor of a cigarette. It's okay to say you don't know if you don't know.
Do you know whether nicotine has been found to contribute to the acceptability of the flavor of a cigarette? Do you know?
A. I think in what limited knowledge I have there, is I think, obviously, the tobacco industry, at least when I hear, they always say

that nicotine is in there for flavoring. At least that's where I think most of the researchers, that nicotine is basically in tobacco products because all tobacco products are seen as nicotine-delivery systems. Where I think, where I hear that debate or discussion or whatever going on is I hear the tobacco industry saying, Oh, no, it's for flavor, that it's not for any addictive purposes or whatever.
Q. Are there cigarette flavor acceptability studies that have shown that nicotine is a major contributor to the acceptability of the cigarette flavor?
A. Again, that's not what I do, and I don't read that. I'm just talking kind of hearsay information that I hear. So I would prefer to say that I don't know. I think we would be better off.
Q. Because of that, I will move to strike your answer prior as having been based on hearsay and as having consisted of the rankest form of speculation.
Is taste, the taste of a cigarette an important determinant of smoking behavior?
A. What do you mean "smoking behavior"?

Q. How much somebody smokes, how many cigarettes they smoke a day.
A. Yeah. I think there's some people that will actually say they like the taste of cigarettes. I think there's a small percentage of people. Most people that come into our center, I think, people that, in fact, have quit, many of them will say that they miss the taste or that taste in their mouth. So evidently they are talking about taste. So, others simply don't miss the taste. They say that it tastes terrible or whatever.
Q. You told me yesterday that there were all sorts of nicotine-replacement therapies that have been shown not to be efficacious, that have been shown not to work. Can you give us a list of those, please?
A. No. Hopefully, I didn't say nicotine-replacement therapies. Basically, I just talked about pharmacological adjuncts. There's other

pharmacological adjuncts.
Every nicotine-replacement therapy that's been tested has, in fact, been found to work.

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I don't know if I, in fact, said nicotine-replacement therapy, and hopefully you misunderstood. That's not, I probably specifically meant pharmacological adjuncts.
Q. Okay.
A. The gum is available; the patch is available; the nasal spray; the oral inhaler. Those are the only real nicotine-replacement therapy products, and all have been approved.
There's a couple that others are looking at, a sublingual tablet. And I think someone is looking at a nicotine lollipop. But everything that has been tested as an NRT has, in fact, been approved. There's other pharmacological adjuncts that haven't.
Q. Nicotine lollipop?
A. Uh-huh.
Q. Who is looking at that?
A. I think I'm not allowed to share that information.
Q. Are you getting paid money from the company that's researching the nicotine lollipop?
A. No. I'm not.
Q. Is your center getting paid money from

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them?
A. No.
Q. Is your wife getting any soft money from that company?
A. No. No one is. I was basically contacted, if I might be interested in participating at a future date in a research project. And I told them that I was not interested at this time, we had more projects than we could handle.
It's a small company, and I think they looking for funds anyway. So I think, it's not something that I would want to particularly participate in, as well.
Q. Have any of these multinational pharmaceutical companies that have paid you money and paid your center money and funded the soft money that's gone to your wife ever had you test or study a pharmacological adjunct that you found to be not efficacious?
MR. GOLDBERG: Objection to form.
A. Could you repeat that? Because I will answer it --
Q. Yeah. Could you read that back,

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please?
REPORTER: "Have any of these multinational pharmaceutical companies that have paid you money and paid your center money and funded the soft money that's gone to your wife ever had you test for a study of pharmacological adjuncts that you found to be not efficacious?"
A. First of all, yes, I mean, they've

paid us. In other words, we get a grant. Let me show you the process. It's a really long question, and there's a lot of pieces to this, in my opinion.

First of all --

Q. I would be happy to rephrase.

A. What I'd like, just allow me to answer the question.

MR. ROWLEY: I'm withdrawing the question.

MR. GOLDBERG: He is going to withdraw it. Let him withdraw it. It will speed it up. I agree with you.

THE DEPONENT: There's a lot of pieces to that.

MR. GOLDBERG: He's going to restate it. And maybe it will be -- I had objected to it,

too.

BY MR. ROWLEY:

Q. Have any of the pharmaceutical companies that have either paid you money or the center money ever had you test or request that you test a pharmacologic adjunct that you found to be non-efficacious?

A. Yes. And, actually, let me finish. Yes. I need to make it clear, too, that they don't pay me or the Center. That's not -- The money goes to the research corporation who, in fact, monitors to make sure the money goes in the proper places and so forth. They don't pay the Center per se. They pay the research, West Virginia Research Corporation that, in fact, disburses those kinds of monies. Those are referred to as grant monies.

Actually, the word "soft" I don't particularly like, even though I have used it. When you say it, it doesn't sound very nice or something. But it is basically, it is grant money. We get a research grant. And, yes, we, in fact, found products that, where we got a grant and, in fact, were not approved.

Q. What company -- Well, first tell me

the product that you found that was not, that you found was not efficacious.

MR. GOLDBERG: Objection if confidential.

Q. Go ahead.

A. I think we basically found lobeline sulfate was not effective.

Actually, let me glance very quickly at my little page here. That way I can make sure and not miss one for you.

I think lobeline sulfate was one.

Q. Actually, the one that has my little one-page resumT. Here it is. I was hoping I would -- trying to remember. Okay. I can tell you there is two in here in particular. Would you like me to respond or wait for you?

.

Q. No. Go ahead.

A. In terms of one of the compounds that we found that was not effective was lobeline sulfate, which is produced by one of the companies.

And that was found not to be efficacious.
Another one was, in fact, recently
that was closed because it was found not to be

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efficacious is, in fact, Buspar as well. In the
literature there was some people thought that it
worked and small studies had been done. So it was
finally done in a major study. It was found not to
be efficacious to help people stop smoking.
So those are two that quickly come to
mind.
We tested another drug that is, in
fact, confidential. But we tested it in
combination with another, with an NRT. I can tell
you all that it was an antihypertensive drug in
combination, because I don't think I'm allowed to
share that medication at this point. But that one
in particular was found to be not effective.
So many of the newer compounds that
people are looking at, actually, we found more
failures than actual successes.
Q. Is there a threshold for a supposedly
addictive amount of nicotine?
A. I'm not -- Can you help me?
Q. Is there a threshold of exposure below
which nicotine cannot be addictive?
A. I don't know that question. I'm sure
there are some individual variability there. I

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can't tell that it's at five cigarettes, at 20
cigarettes or 100. That's not . . .
Q. Is that within the scope of your
expertise?
A. No. I could not tell you that. If I
had, I just simply can't share that information. I
don't know it.
Q. Is it more appropriate to express the
amount of smoking in a population in terms of
prevalence or incidence?
A. Again, I typically like to use the
word "prevalence." I think the article that you
showed me this morning that talked about the
incidence in terms of alcohol, as I mentioned in
that, that was a study that was done in the
master's thesis. It was a title of a person or a
master's student that, in fact, completed that.
But I typically almost always report. I mean, my
choice is prevalence.
Q. Define incidence as that term was used
specifically in Exhibit 3, the paper that you
co-authored.
MR. GOLDBERG: Is Exhibit 3 handy?
MR. ROWLEY: Well, no, I'd actually

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like to know whether he knows the answer without
looking at the paper.
The point of my question, in fact, is
to determine whether, as he sits here, he knows the
answer without looking it up. That's why I'm
asking.
Q. Go ahead, Doctor.
MR. GOLDBERG: We object to that type
of question without showing the witness the

reference.
MR. ROWLEY: If I showed him the answers to all of my questions, there would be no point in asking him those questions.
Q. Go head, Doctor. Excuse me. You just heard the reason that I asked the question. So may I have the Exhibit back?
MR. GOLDBERG: If you are unable to answer the question, Doctor --
Q. Just say it. Just say that you don't know. It's fine for you to say you don't know. If you don't know without looking it up, just say it.
A. What's the question, again?
Q. What is the definition of incidence as the term incidence was used in Exhibit 3?

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Exhibit 3 is the paper that you co-authored in Wellness Perspectives, with Ms. Lane and a co-author whose last name is Wang.
A. When was that published?
Q. 1994.
A. That's five years ago. I can't remember every operational definition and how they did that. I think that would be real difficult for me to recall unless I actually saw the paper. Just no way. I mean, that's a long time ago. We do a lot of study and a lot of work, and I can't remember the exact definition of things that I published a long time ago.
I just, as a matter of fact, this happens often because we do publish a lot of papers. We find that people will study your papers and sometimes know your papers better than you do, because they study them very closely.
Unfortunately, that was five years ago. And I really can't remember the operational definition that was used there.
Q. Is there more than one operational definition of incidence?
A. In terms of that paper?

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Q. In science, is there more than one operational definition of incidence?
A. I really couldn't answer that question, to be perfectly honest.
Q. Okay. Thank you.
Take a look at page 4 of your second report, which is Exhibit 2. Do you see the last sentence under Section 7? It starts with, Because smokers. Do you see that?
A. Yes.
Q. You said in this report, Because smokers are addicted --
By the way, what specific criteria, what set of criteria for addiction did you use in making this assertion?
A. The smokers, in fact, that are addicted, and, again, because of all the tools that we use, we have a pretty good idea who is addicted and who is not addicted when we apply that. In there, that statement in particular is a general statement based on what we have worked with over the past years and our experience and our judgment

and 25 years of working with nicotine-dependent patients.

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Q. The criterion you're talking about, criteria are the methods that you have described in the deposition; is that right?
A. Ask that question again.
Q. Forget it. Let me ask you another question.
You say, Because smokers are addicted, their effort to quit smoking is substantially impeded and is not a matter of free choice but of overcoming an addiction.
A. Yes. I feel very confident of that.
Q. That's your opinion?
A. I think that's my opinion and probably most of the scientific and research people that are out there. I think if you read, even though there isn't any reference on that, I think it would be very, very easy to find a reference for that. As a matter of fact, I could find you a lot of references. That's relatively easy.
I think when people become addicted, it does become very difficult because of the withdrawal and what happens. And that's the entire purpose of all those products that are being developed and being looked at.

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Q. And if you look at the second sentence in that paragraph, you equate the phrase "free choice" with "free will"?
MR. GOLDBERG: Beginning where?
MR. ROWLEY: It starts, "Unfortunately."
Q. You say "free will," and then in parentheses you have "choice"; right?
MR. GOLDBERG: Objection. That's with reference to the clause "the lay person believes." Read the whole thing.
Q. Is there a difference between free will and free choice, Doctor?
A. Probably the way that it's stated here, you need to be very clear, you are just pulling bits and pieces out and half-sentences and half-truths and so forth. Basically, the entire sentences reads, Unfortunately, because some persons have been able to quit on their own, the lay person believes that quitting smoking may be a matter of free will -- and I have "choice" in there.
So in a sense I'm sort of equating the two there. I'm calling it free will, choice, I'm

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sort of explaining it a little bit further.
And there's a lot of people that, in fact, believe that they can quit on their own. But we find that, when we come into the treatment facility, that they can't. Just like I didn't think I was addicted.
So some people do think that it is a matter of free will or free choice, in other words, that you should be able to quit on your own.
Q. Let me ask you the question again.

Is free will the same thing as free choice?
A. Yes. I think, again, just as long as you understand the rest of the sentence there. I'm trying to explain free will is explaining having a choice, yes.
Q. As the phrases "free will" and "free choice" are used in your September 3, 1999, report, they mean the same thing. Is that fair?
A. I think one is sort of a clarification of the other. Again, I'm referring specifically to lay persons that believe that it is free will, or in parentheses that it is a free choice, or whatever. So they are pretty close. One sort of

may be explaining a little bit further the other one.
Q. Which one explains further the other one?
A. In my opinion, I just wanted to make free will, that it is, some people think that it is a choice. And a choice is, in fact, a free will. So, I mean, they are very close. We are talking real shades of subtlety here. But they are pretty much the same.
Q. Is addiction the absence of free choice?
A. Is addiction? Yes, I would believe so. I think if a person is addicted I don't think they really have a free choice.
Q. Therefore, addiction is the absence of free will.
A. Therefore, what?
Q. Addiction is also the absence of free will?
A. Yes.
Q. When you quit smoking, had your free will been eliminated by your smoking?
A. I think I made a choice to try to

quit, and I think that's really important. I think there is a real difference there. In other words, someone continues to smoke because of the addiction. And I made a decision that I was, in fact, going to quit. And I was motivated by the fear that I, in fact, was beginning to get hooked. So I made a decision to quit.
Because what we find in tobacco addiction, it is very much like the alcoholic in the sense that if the alcoholic doesn't want to quit smoking, excuse me, if the alcoholic doesn't want to quit drinking, no matter what I do or assist them with, it's not going to help them. It's the same way with the smokers. If they don't want to quit then there's nothing that I can do to assist them with. So there is a certain free choice to make a decision possibly to quit. But those people are going to need some assistance.
Q. Did you make a choice to quit?
A. Yeah. I made a very frightened choice to quit.
Q. Was it a free choice?
A. I guess I was sort of motivated by my

withdrawal symptoms and how I reacted to not having

nicotine. So in a sense I did make a choice. But it was after the result of what had happened, me going through withdrawal.

Q. In fact, it was the withdrawal symptoms that caused you to make the free choice?

A. I don't know about free choice. To make the choice to, in fact, make a decision to quit.

Q. It was the withdrawal symptoms that motivated you to make the choice; true?

A. I think, that's probably you're characterizing it. Generalizing, I think that is probably pretty accurate.

Q. Was your choice to quit which was motivated by your recognition of withdrawal symptoms a free choice, as you use that phrase in your report?

A. Yeah. I think probably to a certain degree.

You also need to understand, because we are getting caught up again on little semantics, is what you are doing, is trying little subtleties and so forth. The bottom line is if you look again -- and I have not done that research -- what you

really find is, I've noticed actually a very conservative number here, in one of these two reports, I think 8 to 10 percent of the people, in fact, do make a decision to quit on their own and, in fact, are successful.

Some of the numbers go as low as two percent or whatever, I mean, that do that. So I was very, given 8 to 10 percent do quit on their own, I was one of those lucky people that was able to quit on my own. So for me it was a free choice in the sense that I made a decision and I tried to quit and I beat it, where for others it simply is not there.

What we are finding now is we have a different kind of smoker. These smokers have made several attempts.

Q. So it is the either 2 percent or 8 to 10 percent of the people who have free will or free choice, and the rest of the smokers don't have free will or free choice; is that true or not?

A. I think they have limited or impaired choice in the other percent. In other words, basically what you have got is those people that succeed, I think if you look at the literature, 70

to 90 percent of the people, in fact, want to quit, so at least on the self-reports in the studies.

So that being the case, I think once you get addicted it becomes more of an impaired choice. It's just not a matter of yes or no. Obviously, you have to make a decision. But it becomes much more difficult then than someone that, in fact, for whatever reasons, like the woman that had Buerger's Disease and lost a limb or someone that had cancer or whatever, they are highly motivated and they do everything they possibly can.

And they will stick to the withdrawal symptoms and it becomes difficult for them. They are using the gum or Bupropion or whatever, and they really do what they can best to, in fact, stay off the cigarettes.

Q. Did the 8 to 10 percent of people who quit on their own without help make an impaired choice, as you use that?

A. The 8 to 10 percent?

Q. Yes.

A. I think probably they had some. And there is degrees of imparity. It's just not a simple yes or no.

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I am sure for me, as a perfect example, when I tried to quit it was very difficult. I'm chewing cigarettes to try to quit. But realizing that I might get addicted, I was still able to quit even though that was an impaired choice. It was very difficult for me to sustain some of those withdrawal symptoms and to do it. And we see that all the time.

Again, as I said earlier, for whatever reason a person starts smoking, say they start smoking to feel good, once they get hooked or addicted or dependence occurs, they simply, thereafter, they don't continue to smoke to feel good; they smoke to keep from feeling bad.

So I think at different degrees and different levels they have impaired choice. I don't see what is so complicated about that.

Q. How many people in the United States have quit smoking?

A. I can't tell you. I have not counted them personally.

Q. It's something like 60 million, isn't it, Doctor?

A. Yeah. I think the number typically is

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60-some. I know, I can tell you this statement, that I have heard several times -- and, again, I have not counted them. I just didn't want to get in those little subtleties and disagreements again -- a statement, and what I read in some of the literature, there is now more smokers that have quit than there are current smokers.

Q. There are more former smokers than current smokers.

A. Yes. You said that better than I. Thank you.

Q. You know, of course, from reading the same literature, the kind of companion statement with that statement, the one that almost is always stated after that statement, and that is that approximately 90 percent of those 60 million people quit without the benefit of professional intervention?

A. Yes.

Q. Which means that 90 percent of those, approximately 90 percent of those 60 million people quit without gum; correct?

A. Correct.

Q. Quit without the patch?

A. Correct.
Q. Quit without inhalers; correct?
A. Correct.
Q. Quit without hypnosis?
A. Correct.
Q. Quit without counseling; correct?
A. Correct, yes.
Q. Quit without seeing you or anybody like you?
A. Uh-huh.
Q. Correct?
A. Correct.
Q. That's about 54 million people who have quit smoking without the benefit of a smoking-cessation program; correct?
A. Yes.
You need to keep that in perspective, too.
Q. I didn't ask that. I just asked you --
A. No. Let me finish. There is more to the answer. It's not a simple yes or no, what you are looking for. What you are really doing there is distorting the results.

Of course, the little calculation that you did there that seemed so easy. What you are talking about, up until 20 years ago really, or '84, there was simply no nicotine-replacement therapy. So a lot of people had quit before that. It was available 25 years ago in Sweden or other places, but it simply wasn't available. And more products are coming on board.
Plus, that number is beginning to slowly change, because you have a different kind of smoker today -- I mentioned this before, yesterday -- different kind of smoker in the sense that the smoker today is a little more recalcitrant and a little more addicted. That person has made more attempts at quitting smoking than in years past. Therefore, these people, in fact, need help.
And everyone, you can't sit there and wait in hopes that they quit. What you need to do is make a program available to them so they can step up to the plate and hopefully make an effort to quit, because what we are finding is that more and more people are wanting assistance and wanting to quit.
So your calculation is, you didn't

take into consideration the millions of the people that have quit before when nothing was, in fact, available; they, in fact, did quit on their own.
Q. 54 million people were able to quit on their own before nicotine-replacement therapies were available. Is that true?
A. I think not on your calculations. I think there was a large percentage of those previous to nicotine-replacement therapy that quit.
But 54 million, I think, there's 50, I don't know, 50, 60 million, somewhere in that vicinity, as you mentioned, of people that have, in

fact, quit. But that's also from that period of time. So that would be, the calculation would be incorrect, or the number you quoted would be incorrect to say previous to nicotine-replacement therapy.

Q. Some of those 54 million people who have quit without nicotine-replacement therapy or any other professional intervention quit after the availability of nicotine-replacement therapy?

A. Yes.

Q. What percentage of current smokers quit per year before 1984?

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A. I couldn't quote you that number, unless it's in my report somewhere, or whatever. I don't think it is. It might be because of quoting the number. But that number doesn't come to me quickly. I don't have a handle on it.

Q. What percentage of current smokers quit last year?

A. I couldn't give you that number as well. I don't keep all of those numbers.

Q. Was the percentage of current smokers who quit before 1984, annually, the annual percentage, higher or lower than in --

A. I couldn't tell you that.

Q. Was it higher or lower than the annual percentage of smokers who quit last year or the year before or the year before?

A. I don't know. I don't keep those numbers in my head.

Q. So as you sit here, as far as you know, last year a higher percentage of current smokers quit than the percentage of current smokers in 1983, for example?

MR. GOLDBERG: Object to the form.

Q. Is that true?

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A. I guess I'm not -- Could you repeat that again? I'm not --

Q. As far as you know, last year the percentage of smokers who quit was higher than the percentage of smokers who quit in 1983?

A. I can't tell you in terms of the literature, because I don't have exact numbers in my head of who quit more than who or whatever.

Q. That't not what I asked you.

A. I do know that my experience is that there's a difference, we're finding that more and more people are, in fact, coming in to want to quit for a variety of reasons -- expense, cigarettes are getting expensive. There's many things, health reasons, a variety of reasons.

Q. When someone who has had difficulty quitting smoking comes to see you, do you restore their free will?

A. Restore their free will?

Q. These are the people who you say are without free will. Do you restore their free will?

A. I don't think I said without free will. I thought we were talking about impaired will or whatever.

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We don't restore. We try to assist them or motivate them in some way. But usually if they come to us they are somewhat motivated. We don't just go out in the street and randomly assign drugs or whatever. People that come to us are slightly motivated. So they have made a choice. So we don't instill free choice or free will.

Q. Did the approximately 54 million Americans who quit smoking with no smoking-cessation program and no professional intervention and no nicotine-replacement and no counseling quit out of free choice?

A. You need -- Again, you're incorrect in the number that you just gave and the way that you worked it. You said without nicotine-replacement therapy and so forth. And that's the number of people that have been said that have been reported to have quit to date. That's not non-nicotine or the non-nicotine replacement therapy.

Q. Let me ask you --

A. The way you stated the question, or at least -- let me finish.

The way you stated the question, or at least that I understood it, is you started out

saying that 60 million people had quit on their own to date.

Q. No, sir. I said 54 million, unless I misspoke.

A. No, no. You said --

Q. I may have misspoke. Let's get it clarified.

MR. GOLDBERG: Do you want to restate your question?

MR. ROWLEY: Yeah. Let's just clarify it.

MR. GOLDBERG: He is withdrawing the question, and he will restate the question.

Q. I obviously misspoke, for which I apologize to you.

Did the 54 million Americans who quit without the aid of any type of smoking-cessation program have a free choice to quit?

A. Again, originally when you started back with the 60 million, when you said 60 million, you said 60 million that have quit to date, approximately, that accompanied that other statement. So to date includes people at NRT.

In your question you are saying that

people that quit, 54 million had quit without NRT, or whatever. In other words, you are talking just the people that, in fact, have quit without -- making this clear --

Q. Yes.

A. -- in my mind -- without any assistance or help?

Q. Yes. I'm talking --

A. I got you. I got you. I just wanted to make sure, because some of the questions can --

Q. Yes.

A. -- get rather long.

Q. Yes.

A. First of all, I do need to make -- You started with the 60 million. Typically, the number that I have heard, I'm not, that's where you started originally with that 90 percent, I think. That number in particular, I don't go out and count them or whatever.

Typically, what I hear in the literature and so forth is that now we have more smokers, or excuse me, ex-smokers than current smokers.

If you look at the numbers again,

depending on who you are quoting, you're looking 43, 45 million.

So I would see that number, just for a little clarification, probably closer, that you are talking about as 45, 50 million, to start with, rather than your 60 million that, in fact, have quit.

So I think you're starting a little high and inflating. I'd have to go back and look at some of those numbers again and be able to look at that literature.

But to me that is a substantial difference from what I think that I have read. Again, I can't get a handle on it or whatever.

Q. Doctor, if it is 45 million who have quit, and 90 percent have quit without professional intervention, that means that 40,500,000 have quit without professional intervention?

MR. GOLDBERG: Objection.

Q. Is at that true?

MR. GOLDBERG: Vague.

Q. Is that true?

A. I would venture to say that if, in fact, all of those numbers that you gave are

correct, that that is probably accurate.

Q. The number that you have seen is 45 to 50 million?

A. Yeah. I mean, I have seen it. Usually the number, and I don't even know if I have seen the number as much as I have seen that there's a little bit, there is now more smokers, ex-smokers than current smokers.

So I don't know how many smokers supposedly there are in the CDC studies. I have a general idea.

I think 60 to me seemed a little excessive. But, in fact, you even might be right.

Q. I wasn't asserting that that number was correct. I merely asked you the question.

How many current smokers are there in the United States?

A. I think, again, there's a variety, different surveys, different years. An, typically, probably some of the numbers I see may be as low as 43 million or something like that; and they might go as high as 48, 50 million, something.

Q. So the number of ex-smokers is between a number that is higher than 43 million and a

number that is higher than 48 million?

A. Yeah. Somewhere in there.
Q. So it's, in very round numbers, the number of ex-smokers is say 45 million to 49 million?
A. Yeah, something like that. I think that's . . .
Q. Did the 90 percent of those smokers who quit without professional intervention have a free choice to quit?
A. I am sure that they had a free choice. Again, I think it was so subtle a difference. It was just not free choice and no choice. I think there's a slightly impaired choice, because some of those people, in fact, quit on their own. I have known family members, people that, in fact, quit on their own. You ask them, they say, Oh, yes, it was difficult. I had to hide my cigarettes. I had to do all that. Even though they quit on their own, it was not easy for them.
Q. How many of the 40-plus million people who quit on their own were addicted?
A. I didn't evaluate those people or whatever. They didn't come through the Center.

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Q. Can you give us just a rough estimate of the number of the 40-plus million people who quit on their own who were addicted?
A. I don't know that number at all. Unless we evaluate them or something, I wouldn't know that number at all.
Q. That's because in order to know whether somebody is addicted you've got to evaluate them.
A. Yes. I think we do.
Q. You mentioned before -- let me recall what you said -- You mentioned the effects of taxes on the price of cigarettes and the effect of price of cigarettes on smoking prevalence. Do you recall mentioning that?
A. Smoking preference?
Q. Prevalence. On the number of people who smoke.
A. Yes.
Q. It is a fact that when the price of cigarettes goes up smoking prevalence goes down?
A. Again, I'm not an economist. But that's typically what I hear, is that as cigarettes go up, some people, we get people all the time when

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they go up to $2.00 or $2.50, and there's always a small percentage of the people that it becomes a little expense. And there's always a small group, when the price goes up, it's very important to them that they, in fact, then quit.
Q. In fact, there were recent new reports, which I am sure you saw since this is your field, that showed, that reported a marked decrease in smoking prevalence in California as a result of a recently tax increase in cigarettes. You saw that?
A. Yes. I think I am familiar with that, some of that, or at least some of it.
Q. And it wasn't a small reduction in

smoking prevalence, was it?
A. I don't remember how large or small it was. If you have something to give me at least numbers.
Q. Just to give you -- and I will be happy to show this to you -- to give you a rough idea of the magnitude, this is a news report from the St. Louis Post Dispatch. It says, Since passage of a state cigarette tax of 25 cents in California, cigarette consumption has been reduced

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by 38 percent.
MR. GOLDBERG: What is the date of that report?
MR. ROWLEY: The date is April 23, 1999, St. Louis Post Dispatch.
And that is a statement by Melba R. Moore, M-o-o-r-e, the director of the Tobacco Use Prevention and Control Program of the American Lung Association of eastern Missouri.
MR. GOLDBERG: Do you want to look at that?
Is this off the Internet?
MR. ROWLEY: It is printed from the Internet, but it's from the St. Louis Post Dispatch.
Q. Do you see that, Doctor?
A. Yes.
Q. And that is consistent with other accounts that you have seen, not the precise numbers, but the magnitude of the change in smoking prevalence as a result of a significant increase in tax revenue? That's consistent with other reports that you have seen?
A. I don't know about other reports. And

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this, to me, is very dramatic. That's a big drop, I mean, 38 percent.
I don't know about the other reports. I would have to actually look at all of them and see and compare and say, you know, I could offer my opinion. This is not, increasing 25 cents, I mean, to reduce smoking consumption by 38 percent, that to me is a significant drop. That is 38 percent. That's a third.
Q. Let's say that it resulted in a reduction in smoking prevalence that was half that. That's still a significant reduction in smoking prevalence, isn't it?
A. Yes.
Q. Those people who quit because the price of cigarettes went up, did they have a free choice to quit?
A. Yes. Again, as I said before, everyone has a certain degree of choice. But it is impaired choice, and it is degrees of impaired. Some people have an easier time quitting than others. Some of them are more difficult.
What we are finding in our experience in 25 years of tobacco research is basically that

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over time you have a different kind of smoker. You're having smokers now that are making much more

serious attempts, and they are beginning to seek help because they find out that they couldn't quit on their own.

Basically, what you have gotten rid of a lot are those people that could quit on their own. It's what we refer to as the low-hanging fruit. It's the ones that were easier. Those ones that their impaired choice was not as severe as someone a little further down the line that, in fact, is more addictive.

So it's either, I know that you are addicted, yes or not, or whatever. But there's a certain little level of addiction. So there is some impaired choice.

Q. How many of the 40 to 45-plus million Americans who quit on their own were low-hanging fruit?

A. I couldn't tell you that. My judgment would, it's just a judgment, would, in fact, be a larger portion because that number is becoming smaller. People are having more difficulty quitting on their own.

MR. GOLDBERG: Do you want a break? It's been about an hour and 15 minutes.

THE DEPONENT: Yes, actually I would. It's been longer than that.

MR. GOLDBERG: Is this a convenient place to break?

MR. ROWLEY: Absolutely.

(Break.)

VIDEOGRAPHER: We are now back on the record.

BY MR. ROWLEY:

Q. Doctor, are you familiar with the body of literature that consists of randomized controlled intervention trials among smokers?

A. Some of them, yes. Not the entire body. I'm sure I couldn't quote you every number, statistic or whatever. But I am, generally, sort of familiar with it.

Q. Explain to us, exactly, what is a randomized controlled intervention trial?

A. It's very simple. Someone comes in to a trial, and they are randomly assigned to either active or a placebo. That's a randomized trial. And it's an intervention because we are performing

some kind of intervention. So it's a randomized intervention trial.

Q. Have you ever designed yourself a randomized controlled intervention trial?

A. Not by myself.

Q. Have you ever conducted a randomized controlled intervention trial?

A. Yes. We conduct quite a few of those.

Q. Describe the randomized controlled intervention trials that you have conducted.

A. Can I refer to the --

Q. Just describe generally --

A. The products?

Q. No. What's the typical outcome variable in those studies?

A. Again, what we are, almost all of the studies, typically, what you are looking at --

First of all, let me back up. Randomized trial, I think I explained that before. People come into a study, and they're randomly assigned an active placebo or a variety of ARMs, depending upon what those ARMs are, depending on what you want to look at in terms of outcome variables.

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But really the outcomes that we look at, almost always, we look at just two. We don't, try not to get into a lot of others. We may collect data and have a statistician analyze it and look at those. But because we are testing a product or a concept or idea, basically what we are really looking at is we are testing the pharmacological adjunct in terms of safety, whether it's safe or not, and then, two, for efficacy. So those are the outcome variables that we really want to look at. One is primary and usually one is secondary.

Q. You look to see whether the pharmacological adjunct appears to have some statistically-significant effect on outcome?

A. Exactly.

Q. The odds ratios that you have in your report are from a publication, A Clinical Practice Guideline called Smoking Cessation; is that correct?

A. Which report are those in -- 2?

MR. GOLDBERG: Page 5.

THE DEPONENT: I see it now. Just want to look and make sure that the reference is in

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fact.

MR. ROWLEY: Page 5 of the second notebook?

MR. GOLDBERG: It may be in the first. In your reference on it earlier.

A. That's what I'm looking for. I'm almost positive it is correct. Yes. Okay. That's correct.

Q. Those were the odds ratios that, obviously, you chose to put in the report over other available odds ratios to the extent that there are others available; right?

A. I'm sure, yes, that there are others.

Q. Why did you choose those odds ratios over other odds ratios that are available?

A. Again, this was my opinion. One of the expert groups in the clinical practice guidelines were really developed by the government, as a report, as a matter of fact, to be really specific, the U.S. Department of Health and Human Services Clinical Practices, Guideline Number 8, Smoking-Cessation.

Q. Number 8?

MR. GOLDBERG: No, no, no. You said

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number 8.

MR. ROWLEY: Doctor, I have it. I have it right here.

THE DEPONENT: Oh, number 18. I said 8?

MR. GOLDBERG: Yes.

A. I'm sorry. But, anyway, basically that was very rigorous. In other words, they went through thousands of studies. In fact, they had to meet certain criteria. That's why those numbers may be different. If, in fact, someone else were doing it -- and there's been several studies that have done meta analysis or, in fact, are looking at some of these odds ratios and so forth.

And so that being the case, this one in particular scrutinized, and it is probably, I think it is the booklet, because I mentioned here, The single British compilation of strategies and recommendations designed to assist clinicians, smoking-cessation specialists and healthcare administrators, insurers, purchasers, in identifying tobacco users in supporting and delivering effective smoking-cessation intervention.

So that's why I used that one.

Again, I did not calculate those. I need to make that very clear. I'm not a statistician, epidemiologist. I did not do any of those. I reported those odds ratios.

Q. Did you, if you look at page 5 of your report, look, for example, at the odds ratio associated with group counseling, 2.2. Do you see that? Do you see that?

A. Yes.

Q. What is the extent of variability across studies in odds ratios associated with group counseling?

A. I couldn't tell you that. That's the, in other words, the average odds ratio that came up, I couldn't tell you what the variation is.

Q. Within what range of confidence was that particular odds ratio calculated?

A. I can't remember now unless I went back to the actual report. I just don't remember.

Q. Did you look at the width of the confidence intervals in deciding whether these were the odds ratios that you should put in your report?

A. Again, I'm sure I looked at them and

was familiar with them or whatever. But these odds ratios are the ones that I lifted out of that book. If you look real closely, I forget, there was 30, I am guessing here again, but I believe it was 33, 5, 1, somewhere in that vicinity, large portion of what I considered to be literally the company's top tobacco researchers that participated in that.

Then I believe the number that reviewed it was something like about, I don't know. It was considerably more than actually wrote it and participated in the actual putting together of that report.

So they actually computed and did all of that. And, basically, what I did is I reported what I thought were the most accurate odds ratios.

Q. Doctor, I wonder, are you familiar

with the scientific fallacy called argumentum ab populum? Have you ever heard of that?

A. No.

Q. It is called the bandwagon fallacy. That's the fallacious reasoning that consists of arguing that a scientific proposition is true because most scientists believe it is true.

Have you ever heard of that?

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A. Yes. I have heard of that concept.

Q. In deciding what literature to put in your report, what efforts did you make to ensure that you would not succumb to the scientific fallacy of argumentum ab populum? Tell us specifically what you did to ensure that you did not succumb to that scientific fallacy.

A. I think I have answered that in a whole variety of different ways today. And, basically, what you have to do, because of the number of people that are, in fact, involved, they were in this report in particular, as in other reports, basically, they have peer-reviewed journals or whatever, this one in particular had more than 30 or so, somewhere in vicinity, of the world's tobacco, or specifically, I mean, definitely I could say top tobacco researchers literally in the United States. They came up with this. There was very strict criteria that are outlined in the book, how they eliminate studies and what they did.

I think these are about as good as numbers that you will find anywhere. Not only did that group really went to task and really worked

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very diligently in the way they screened them out, if you could actually get a report and take a look, the criteria were very difficult. And thereafter it was sent out for people to actually review and to look at.

So I guess I could say that in this case, which is, I don't know, maybe 70, 80, maybe as many as 100 of the country's top tobacco researchers that got involved in this, I guess that you could say that that, in fact, is true, whatever.

But the bottom line is I did not go out and do that myself.

Q. Are you familiar with the scientific fallacy known as the appeal to authority? Have you ever heard of that?

A. No.

Q. You never heard of the fallacious reasoning that is known in the literature as the appeal to authority?

A. No.

Q. The appeal to authority, Doctor, is the fallacious argument that a particular scientific proposition is true based upon the

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credentials of the scientists who claim it's true.

What did you do, if anything, Doctor, to ensure that your selection of literature for inclusion in your report, in your selection of that

literature, you did not succumb to the generally recognized scientific fallacy called the appeal to authority?

MR. GOLDBERG: Objection to the form of the question. Move to strike.

Q. Tell us exactly what you did.

A. Basically, again, as I will repeat, I did the exact same thing. I can go through it. The people that, in fact, wrote the report are some of the world's, what I consider the best experts. They are the ones that are quoted. They are the ones that are in the New England Journal of Medicine and JAMA. They are some of the best pharmacologists, I mean, neuroscientists, people involved in cessation.

So they all came together. And through some very strict criteria that I don't have access to right now, but I could get for you, they eliminated and included articles and then came up with this, that is probably the most widely-

disseminated and easily the most respected thing in terms of helping people quit smoking, that people refer to this guide all the time.

Thereafter, it was also sent to, again, to other people to, in fact, evaluate and to look at. As a matter of fact, I was even one of the reviewers that actually reviewed this as well and offered some of my comments and some of my thoughts.

So there were many people involved in this. We are just one -- They, basically, wrote it and put it together. I guess in that sense you could say that I just, my judgment was based on their credentials and what they did and the expertise that they possess.

Q. Have you ever heard of the scientific fallacy or the fallacious line of scientific reasoning called the consensus fallacy?

A. Yes. I have heard it to a certain degree. Yes.

Q. What is that?

A. Huh?

Q. What is it?

A. I would rather you share. I think I

have a general understanding, but I would prefer to say no.

Q. Just give me your general understanding.

A. No. I will just basically say no and let you say it. I don't know.

Q. You said you have heard of it. So tell us --

A. Yeah, but I would prefer not to. I would just as soon -- I'd say, no, that I don't know.

Q. You don't know. Very good. Thank you.

Look, for example, at the odds ratio or group counseling, 2.2. Did that interval of confidence include one or less than one?

A. See, again --

Q. If you don't know, you can say you don't know.
A. I don't know. I did not participate in that.
Q. Did any of these odds ratios that are in excess of one have intervals of confidence that included upon or numbers less than one?

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A. I could not share. I mean, I don't know.
Q. Is it possible for an odds ratio to be less than one?
A. Usually you start with definitely the one, because it's my understanding that you have the one, and from there you actually -- you are talking about the odds ratio or the interval? I'm sorry.
Q. Is it possible for an odds ratio to be less than one?
MR. GOLDBERG: Objection. He asked for a clarification. Are you withdrawing the question and then restating the question? Is that what is going on?
Q. Is it possible for an odds ratio to be less than one?
A. Oh, yes.
Q. Oh, it is?
A. Yes.
Q. What does that mean?
A. Typically, the odds ratio is one. That's more or less the standard. In other words, if you look at 1.2, and then using self-help, in

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terms of no intervention might be 20 percent greater. You could have, it could be less than one. If that's less than one it is just not, basically, not as effective in just doing no intervention at all.
Q. What does it mean --
A. That's a poor example, but you could jump to another one to explain it a little bit better.
Q. What does it mean if the interval of confidence for an odds ratio includes numbers less than one?
A. That it is not as effective as the one that, in fact, is one or higher.
Q. Sir, if the group counseling odds ratio of 2.2, if its interval of confidence included negative one, what would that mean?
A. You are saying negative one?
Q. Negative one.
A. What you did, you started switching back and forth. You say odds ratio, then you go to confidence interval and so forth.
Q. The confidence interval --
MR. GOLDBERG: Repeat it, please.

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Q. I thought he was asking for clarification. Let me clarify the question.
A. I usually like -- Okay.
Q. Let me clarify the question.
If the interval of confidence of the

odds ratio, 2.2, included a negative number, what would that mean?

A. I think probably the best thing for me to do, because you are starting to play, in my opinion, in my judgment, you're starting to try to play little silly games there. So I would prefer just to basically say that I have a limited knowledge in that area. I understand basically what odds ratios are, and that's what I understand, and that's why we statisticians and epidemiologists; and those people that, in fact, do that.

I ask for clarification myself occasionally. And I do know basically what I need to know what an odds ratio is. It tells me, what the numbers are here tell me something. When you start delving deeper, it doesn't tell me anything in particular.

Q. What you're saying is that you don't

need to know -- and, believe me, I'm not being critical of you in any way, and I'm not questioning whether this is correct or not -- you are saying for your purposes in your everyday professional life you don't need to know the significance of a confidence interval that includes a negative number. You just don't need to know that.

A. Typically, what I do -- no, I would probably say that I don't. Only I look at the odds ratio to see what supposedly works better than others.

Q. But you don't know the significance of having an odds ratio that has the -- Let me rephrase.

You do not know the significance of a confidence interval that includes one or a negative number?

A. No.

Q. Thank you. Therefore, even if you had looked at the confidence intervals for these odds ratios in paragraph five of Exhibit 2, and they had included negative numbers, that wouldn't have had much, if any, meaning for you.

A. Yeah. Basically, what I would do with

something like that is walk over, whenever I have a question, because that's not my area of expertise, I walk over to the statistician; and he would, in fact, share information that I might ask him.

Q. And you didn't do that before you put these odds ratios in your report?

A. No. The odds ratios to me as they stand reflect what is more effective than whatever else is.

Q. Here in Table 1 you have a number of odds ratios, and then you have three risk ratios.

A. Uh-huh.

Q. What's the difference between those things?

A. Typically, they're, my interpretation, and limited in having talked to statisticians and so forth, in other words, when data is, in fact, available, and there is a formulation, excuse me, a

formula that you can calculate an odds ratio; and whenever some data are not available to him you can do the risk ratio. But theoretically they are pretty much the same thing.

So to me -- I'm saying to me -- the odds ratios would be very similar in terms of the

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risk ratios.

There are some, a little operational differences, whatever. But according to the statistician, and the way he shared it with me, is that one of them have different kinds of data, or because it were not collected for a variety of reasons, as you said, for all practical purposes odds ratio and risk ratio are very similar.

Q. In the context of Table 1 specifically, you can't explain the difference between an odds ratio and a risk ratio in terms, for example, of the formula that's used?

A. No. I could not.

Q. To the extent that odds ratios and risk ratios may differ in their reliability or the information that they impart regarding the relationships within the variables, you can't explain that, because that's not what you do.

A. Could repeat that again?

Q. To the extent that odds ratios and risk ratios differ with respect to inferences that may be drawn from the data, you can't explain the differences?

A. No. I can make inferences relative to

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the risk ratio and the odds ratio when I look at that. That tells me something. It may not tell you anything, but it tells me something.

Q. Do any of the risk ratios, any of the three risks ratios that you have listed there on page 5 of your report, did any of the confidence intervals for those risk ratios include one?

A. I don't remember, because I didn't, again, that was something that I would exclude. Because, again, this information tells me something, and it tells me what is more effective or what I might use in our actual counseling.

Q. Within a given confidence interval for a risk-ratio estimate or an odds-ratio estimate, is any number within that interval anymore likely to be correct than any other number?

A. Again, that's not the way that I use this. You are asking me things that I --

Q. If you don't know, just say so.

A. I don't know.

Q. Thank you.

A. Yes.

Q. Are the odds ratios that are listed in Exhibit 5 anymore likely to be the correct numbers

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than any other number within the intervals of confidence for these odds ratios?

A. Likely to be what? Excuse me.

Q. Are they anymore likely to be the correct numbers than any of the other numbers that are within the confidence intervals for any of

these estimates? If you don't know, just say so.
A. No. This is the reliable one. In other words, that's typically the average. In other words, what you are getting at, when you're coming in there and what you are looking at is a, excluding the confidence interval, this is the odds ratio, the risk ratio, this tells me something, in other words.
Q. So you're saying that the average number is more likely to be true than any other number within the confidence interval? Is that what you are saying?
A. Typically, again, let me just make this very clear, that as far as the confidence intervals, what I concentrate on and what I want to do, you are asking questions that I refer to statisticians or whatever.
Q. The fact is that the concept of a

confidence interval and its meaning and implications is beyond your expertise; right?
A. It's something that I don't typically use, correct.
Q. You don't purport to really understand what a confidence interval is or understand all of its implications in terms of assessing these odds ratios or risk ratios; that's true?
A. That is probably correct.
Q. You haven't calculated the empirical probability that any of these odds ratios or risk ratios are actually correct; you haven't done that?
A. No. I have not done that.
Q. Very good.
You mentioned meta analysis before. I am sure you are aware that the scientific literature is replete with references to the inherent limitations of the meta analyses.
Enlighten us, if you would, as to what those inherent limitations are.
A. I coudl not really share those with you. As I told you earlier, that when I went to school, in the statistics courses that I took, meta analysis was not a technique that was used; and,

subsequently, now it's being used.
Q. Fair enought?
A. Therefore, we refer to statisticians. Because I took 15, 18 hours of statistics; they have taken 150 hours. They're much more specialists.
Q. Fair enough. That means that for that reason and perhaps for other reasons you're not an expert in meta analyses?
A. No.
Q. And you're not knowledgeable about the inherent or other limitations of meta analyses?
A. No. I'm not.
Q. But you do acknowledge that these odds ratios and risk ratios that, for whatever reason, you chose to put in your report were derived from the meta analyses, specifically a meta analysis that was published in Clinical Practice Guideline number 18; correct?

A. Correct.
Q. Has there ever been a study, Doctor Glover, that you're aware of that was based on a random sample of West Virginia smokers?
A. Study of random sample --

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Q. Of West Virginia smokers as a study population.
A. I'm sure. Yes, I think there have been some.
Q. Really?
A. Yes. I guess what I'm after -- Let me just sort of back up a little bit. When you say as a smoker, I mean, are you talking about habits, patterns? What are you talking about?
Q. Do you know the difference between a study population and a sample population?
A. Typically what we do is we always do sample populations.
Again, I don't get in sampling techniques as much. I have a general understanding of that. Basically, the sampling technique that someone may, in fact, use -- I do know that there are several studies that have been done in the state of West Virginia by others, never by me. I've never done either one of those, because that's not what we depo. Others have done studies. That's not what we do.
Q. You have never done it?
A. No.

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Q. And to the extent that others have done it, you're not an expert in those, because that's not what you do; right?
A. True.
Q. As far as you know, no researcher has ever conducted a scientifically-valid survey of the attributes, risk factor exposures, and smoking habits of the West Virginia population of smokers specifically?
MR. GOLDBERG: Objection as to form. Argumentative and vague.
Q. As far as you know, that hasn't happened?
A. I think, I know several studies have been conducted by other individuals. It's just, again, we don't do survey research. We don't, that's not what we get, we don't get into sampling techniques or whatever.
But I think the State Health Department is always putting out reports and a variety of reports on how many smokers and what they are doing and talking about smokers' habits throughout the state.
I haven't sat down and looked at how

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they sampled and what they did or whatever. But they put out a lot of reports, and I am sure others have. It's just not what I do, again.
Q. Right. But that's not what you do. That's not within the scope of your expertise, because you don't --
A. Yes. I put my energies other places.

Q. Your studies are clinical studies. They're not population studies.
A. Exactly. We are more clinical.
Q. Your expertise is not in population studies. You don't do those. You do clinical studies. Correct?
A. Yeah. We do clinical research.
Q. Can you name for me a specific survey that has purported to gather a statistically-valid sample of all West Virginia smokers?
A. No.
Q. Let me ask you if you agree with this statement, Doctor.
Plaintiffs must take some responsibility if they continue to smoke after receiving medical advice that they quit smoking.
MR. GOLDBERG: Objection. If you are

reading from a document, the doctor has the right to see it.
THE DEPONENT: Yeah, I think --
MR. ROWLEY: It's none of your business whether I am reading from a document.
A. I would like to be able to see what is said before that, or whatever. In other words, I would like to see the context in which that was said.
Q. Let me ask you this --
A. And I believe that is one of my reports.
Q. Let me ask you this, Doctor --
A. You've interrupted me at least three times, and I'm trying to respond.
So what I would like to do is actually locate that, unless you withdraw the question, whatever. I would actually like to try to find it and respond to that, because I think you are pulling a sentence out of context.
MR. ROWLEY: Can either of you enlighten me as to what you are looking for?
THE DEPONENT: Actually, for that paper you will see that sentence that you are

pulling out at random.
MR. ROWLEY: What documents are you looking in?
THE DEPONENT: It has to be in either one or two.
MR. ROWLEY: It does?
THE DEPONENT: I would think.
MR. GOLDBERG: Just wait a minute.
MR. ROWLEY: Well, there was an objection. I will withdraw the question as a result of the objection. So there is no question pending.
BY MR. ROWLEY:
Q. Doctor, let me ask you this: Do you believe that people who --
THE DEPONENT: I think it is in the current reports.
MR. GOLDBERG: He has withdrawn the question.
MR. ROWLEY: I have withdrawn the

question.
Q. Do you believe that people who, smokers who suffer from a smoking-associated disease or who become addicted must take some

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responsibility for their continued smoking after they receive medical advice to quit smoking?
MR. GOLDBERG: Objection to the form of the question. Vague.
Q. Are we thinking about our answer?
A. No. I was just reading basically what you said. Could you ask the question again? I found where you were quoting from.
Q. Okay. I wasn't quoting.
MR. ROWLEY: But can we read the question back?
REPORTER: "Do you believe that people who, smokers who suffer from a smoking-associated disease or who become addicted must take some responsibility for their continued smoking after they receive medical advice to quit smoking?"
A. I think in the face of what you're referring to this, that you said that you were not quoting out of you, you basically are sort of pulling it a little out of context. And what I would like to do is actually read the paragraph.
It says here, Finally, the Plaintiff -- which is the individual that I was talking about -- must take some responsibility as he continues to

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smoke after his father's heart attack in 1974, after medical advice in '92 and '95 that he quit smoking. Moreover, the Plaintiff continued to smoke after his 1996 heart attack and has refused expert advice and warnings from his doctor since 1996 that he quit. This is extremely risky behavior. The decision to smoke in the face of known dangers is a contributing cause of the Plaintiff's initial MI and creates risks of future cardiac adverse events.
In that person's case, I would think that for years he has been told, and he has a little history, and I think that, in fact, it is my opinion that I think he bears a little of the responsibility as well.
Obviously, I think he is making one of those impaired decisions, because it's obvious that he's addicted and he's having difficulty quitting. But he bears a little, he needs, in my opinion, he needs to make an effort.
I think this was, I can't recall this deposition or whatever, but I think this was the second attempt that he was making. And it is obvious he was predisposed to having some problems.

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Q. That was your opinion in November of 1998?
A. Uh-huh.
Q. And it's your opinion today; right?
A. Uh-huh.
Q. In that case you were retained by the defendant; correct?
A. Yes.

Q. And you're making a comment about the adverse party in the lawsuit, the Plaintiff; right? Is that correct?
A. Excuse me?
Q. You're making a comment regarding the plaintiff in the case, who is the adverse party; is that correct?
MR. GOLDBERG: You're holding up the report?
MR. ROWLEY: Yes, sir. I'm holding up the thing that Dr. Glover is looking at.
MR. GOLDBERG: Carrie Kearney (phonetic) regarding, dated November 25, '98.
MR. ROWLEY: Let me have the question read back, please.
REPORTER: "You're making a comment

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regarding the plaintiff in the case, who is an adverse party; is that correct?"
A. Who is what? I'm sorry.
Q. Who is an adverse party, Doctor. That's who you're making a --
A. What are you referring to when you say "adverse party?"
Q. He is a party on the opposite side of the case; right?
A. I'm asking you a question. You don't need to be rude.
Q. Is that right?
A. Excuse me?
Q. Was that who you were making the comments about?
A. Yes.
Q. You were retained by one side, and you were making the comment about the other side?
A. Yes.
Q. That's what you understood at the time?
A. Yes.
Q. And when you said that he must take some responsibility, you didn't say in this report

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that he had an impaired choice, did you?
A. No, I did not. No.
Q. You didn't say that he didn't have free will, did you?
A. But I didn't say it was 100 percent responsibility either.
Q. Doctor, did you say that the man had no free will?
A. Did I say? No.
Q. In fact, Doctor, in the last sentence you said he made a "decision to smoke." Did I quote that correctly?
A. Decision to smoke?
Q. Did I quote that --
A. Yes.
Q. In fact, we want to be fair and give you a complete quote. You said he made "the decision to smoke in the face of known danger," didn't you?
A. Yes.
Q. You didn't say he made an impaired

decision to smoke, did you?
A. No. I did not.
Q. In fact, you said that his decision to

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smoke in the face of a known danger was a contributing cause to his myocardial infarction. That's what you said?
A. Correct.
Q. Rendering medical-causation testimony based upon his decision to smoke; right? That's what that is.
A. I don't know if it is medical testimony, but that's what I said.
Q. Well, sir --
A. When someone asks your opinion, just because you say, I have a cold, or, You have a cold, that's not a, I don't have to be a physician to, in fact, state that. I mean, a cold or whatever. I think you're really being extreme and not, in fact, being very accurate with the information.
Q. It's your testimony that, in your opinion, given your background and experience, that one need not be a physician or even have a medical degree, much less a medical license, to express an opinion as to what caused an individual's myocardial infarction; right?
A. No. That's not what I'm saying. I

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think --
Q. Did you have a medical --
MR. GOLDBERG: Wait, wait. He can answer.
A. Can I finish?
Q. Go ahead.
A. I really would like to finish. You know, you're interrupting --
Q. Go ahead.
A. I think -- You're doing it again.
Q. Please finish.
A. You're doing it again. It would be nice if I could actually finish a sentence here.
Q. Please do.
A. You're doing it again. Please allow me to finish.
But, anyway, I think that in that case just knowing that, in fact, smoking, in fact, may cause an MI, you know, it doesn't take a real genius, you don't need a medical degree, you don't need a medical license or whatever, that if someone continues to smoke that they, in fact, may get an MI. I don't see anything particularly difficult about that. If people, in fact, have an MI, if

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they smoke, if they continue to smoke, they could have an MI.
Q. Did you say, Doctor, that if he continued to smoke he may have an MI, or did you express the expert opinion that his decision to smoke was a "contributing cause" of his MI?
A. I'll read the sentence exactly. It says -- this is what I said -- I said, The decision to smoke in the face of known danger is a

contributing cause of the Plaintiff's initial MI and creates a risk of future cardiac adverse events.

Again, you look at their contributing cause, you know, there could be many, many causes, and, obviously, addiction is a large part of that, which you are excluding all together and you're playing up this other part about free will and so forth, or his decision, and that's part of it.

As I told you before, people have to ultimately make a decision to quit. That, in fact, may be an impaired choice. I may not have used that terminology. But a person has to make a decision or a choice to, in fact, want to quit.

And I think that, in my opinion, based

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on this, and as many times as he had been warned and told, and his history and so forth, I think he had to accept a certain portion of the responsibility.

Q. Was Mr. Steiner addicted?

A. By looking at this, just generally, I would venture to say that he appeared to be, just by some of the, he was trying to quit, and what he was doing and so forth.

But I couldn't tell you for sure unless I would have evaluated him and brought him into the Center and run through our battery of tests.

But it is my impression that -- and it's strictly a judgment -- and from what is written here, and I can't remember the case note, a great deal of it, but some of the things that, in fact, was experiencing, that I could say with a certain amount of certainty, but I can't tell you for sure that he was addicted or not, but I believe he was.

Q. Even though, in your opinion, Mr. Steiner was addicted, he decided to smoke in the face of a known danger. That's true?

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A. Could you repeat that again?

Q. Even though it is your opinion that Mr. Steiner was addicted, he decided to smoke in the face of known danger?

MR. GOLDBERG: Object to the form of the question.

Q. That's true?

A. I guess -- Will you repeat that one time for me? I'm sorry. I want to make sure you're not playing little word games and switching things around here. It's getting late in the day.

REPORTER: "Even though it is your opinion that Mr. Steiner was addicted, he decided to smoke in the face of known danger."

A. I think decided, that's a part of it. In other words, it is just not, I think addiction played a part, and I think his choice played a part. I think he has to take, nothing particularly confusing or profound about that he, that there's both parts there. It's just not one or the other. You keep drawing lines in the sand, it's either this or that. That's simply not the case.

As I said there, it's a contributing cause. There's other causes as well. If you were

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to ask me, my professional judgment or whatever, I would venture to say, even though we didn't do the extensive battery of tests, that probably the overriding concern for this individual was, in fact, the addiction. But he still had some choice there, whatever choice that may be or whatever. It may be an impaired choice or whatever, but he continued to smoke, so he has to accept a little bit of the responsibility.

MR. ROWLEY: Move to strike as non-responsive.

Q. Doctor, did this addicted man decide to smoke in the face of known danger?

MR. GOLDBERG: Objection.

A. Did this addicted man decide to smoke in the face of known danger.

Yes, I think he did. When you get to there I think you say yes to that.

Q. Let me ask you this: Do you agree that in a clinical setting cessation treatments, even as brief as three minutes a visit, are effective?

A. Yes. Can be.

Q. Do you agree that clinicians, as

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things stand today, with no additional smoking-cessation programs other than the ones that are in existence today, in the State of West Virginia, clinicians have unique access to individuals who use tobacco?

A. That clinicians in West Virginia have access to people that use tobacco.

Q. Unique access to individuals who use tobacco. Do you agree with that statement?

MR. GOLDBERG: Objection to the form, very vague.

A. Yeah. I'm not sure what you mean "unique access."

Q. Are you familiar with the English word "unique"?

A. Yes. But I don't know how you're using it. What do you mean "unique"?

Q. Is there more than one definition of unique?

A. I don't know. That's why I'm asking. I don't know what you mean "unique." You have added, I don't know what you are trying to prove or to say or whatever. I'm not sure what you mean "unique." Leave out the word "unique" and it may

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be a little easier to your answer.

Q. Is it your testimony, Doctor, that you are unable to answer the question?

A. No. I think if you ask the question and leave out the word, because I don't know what your operational definition of the word "unique" is, if you would just leave out the word "unique," then I would respond to it, I think.

Q. You are unable to answer the question as asked? Is that --

A. Because I'm not sure, yes, because I don't know what you mean by "unique." If you gave me an operational definition I would share that with you.
Q. Is it true that more than 70 percent of smoking Americans visit a clinician each year?
A. I think that's a roundly-held number, somewhere in that vicinity, yes.
Q. It's more than 70 percent. Do you know how much more than 70 percent?
A. No. I know that a large percentage. I think 70 is -- I don't know if anyone really knows the exact number, but I think 70 is typically what, according to the literature, I know the large

percentage of them do. 70, I think, is the most common number.
Q. Do you agree that as things stand right now, in the State of West Virginia, in the current state of affairs, with whatever smoking-cessation programs are in effect, that all patients who visit their primary care physicians and who use tobacco should be offered motivational interventions and effective treatments to overcome their habit?
MR. GOLDBERG: Objection to the form. It is vague.
A. I think you said "habit" there. I think there's a little difference in the habit and then the addiction. I think if you substituted the word "addiction" I would probably respond yes to that. But I am not really sure when you say habit.
Q. It should be limited to folks who are addicted, not people who choose to smoke voluntarily, is what you are saying?
A. No. I mean, yes, in a sense. It's kind of a little tricky question there. Again, you're trying to draw lines and say "yes" or "no."
Basically, here is what I think,

because you are trying to pin me in corners, or whatever, basically, what I'm saying and what I think needs to be available, and I think everybody that is a smoker, because some of the people do not know that they are addicted or whatever, so I think that smoking-cessation programs need to be available to all West Virginians who, in fact, smoke so they can come in and become, actually be, a diagnosis to see if they are dependent and see if they, in fact, want to quit. So if they'd want to quit and if they'd come in, we can provide to see if they're dependent number one, and high/low dependence, and then work with them appropriately in trying to help them. That's what I believe. I think you will take bits and pieces of things to try to distort and change, which I can't quite agree with completely. That's why my answers are sometimes long.
Q. Is addiction an injury?
A. Injury in what way?
Q. Can you answer the question as phrased?
A. I guess I'm not sure what you mean,

what you mean "injury."

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Addiction, I would see it as a disease. I think everyone is beginning to see smoking as a disease. I don't know, I don't see anything wrong. I'm asking what do you mean by injury?

Q. Addiction in your view is a disease. Is that true?

A. In my view addiction is a disease? I think, yes.

Q. Someone who is addicted has an existing disease. Is that your view?

A. Yes.

Q. Are you permitted at your Center to diagnose disease?

A. I think we are permitted to diagnose nicotine addiction.

Q. Are you permitted to diagnose disease?

MR. GOLDBERG: Objection to form and vague. Are you referring to disease other than nicotine addiction, or just the disease nicotine addiction?

Q. Are you permitted to diagnose disease?

MR. GOLDBERG: Object.

A. I'm permitted to diagnose nicotine.

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Other diseases, that's not what I do.

Q. Is addiction more accurately characterized as a condition or a disease?

A. Condition or disease?

Q. What's the better, what's the more appropriate label for it?

A. For me, I think, our feeling is that smoking is a chronic-relapse type of disease, specifically.

Q. Can you cite me to any literature or any reference anywhere that refers to addiction as a disease?

A. Not right offhand. But it would be real easy to. I think smoking is beginning to be seen by most researchers as a disease, and I think there are some papers. I can't quote you right offhand. But, again, that would be relatively easy, because I have begun to see that.

And a lot of people are beginning to be seeing smoking as a chronic-relapse type of disease. They are trying to equate it much very much to alcohol, very similar. Once a smoker, always a smoker, possibly.

Because we find that some people who

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come into the Center, in fact, have not smoked in 20 or 30 years. They will say that virtually there isn't a day that doesn't go by that they don't think about cigarettes.

And there is a high relapse rate over time. So I think that's the common view that's being held. So if you would like for me to, I can't quote you those articles right off the top of my head, but one or two would be relatively easy to provide.

And I think also even the

pharmaceutical companies, they are beginning to see it as a chronic-relapsing type of disease, because our interactions with the FDA are, in fact, that way. And they're thinking about treatments differently as well.

Q. What is the difference between a disease and a condition?

A. I don't, condition, I would see that as something that someone possesses. I don't know, I imagine, in this case, they would be very similar. I have no idea. But for me, we use it as a chronic-relapsing type of disease, is what we use.

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Q. What is the definition of disease?

MR. GOLDBERG: Object to form, vague. What do you mean? Whose definition?

Q. What is the definition of disease under which you have concluded that addiction is a disease?

A. Again, that is the widely-held belief of most of the people that are, in fact, providing research. And it is being called a chronic-relapsing type of a disease. Therefore, I think I would tend to agree with that in terms of relapsing, because people, in fact, are relapsing all the time. And what we find is over time there is relapsing that occurs with smoking.

So in that sense, I would argue that for that limited definition, it may not fit what you want, but to me that would be seen as disease.

I can't identify a disease in terms of a definition to you. But, again, I just work in the nicotine area. I don't work in other medical conditions.

MR. GOLDBERG: Do you need a break? Do you want a break?

THE DEPONENT: Actually, yeah. Could

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we just take a moment here? Could we have a break, please? It's the second time it's been asked. Could we have a break?

MR. ROWLEY: Oh, absolutely. Certainly.

(Break.)

MR. ROWLEY: For the record, the witness has requested that we stop the questioning for the day, and we are certainly going to honor his request.

As a consequence of that request, we are going to suspend the deposition at this time, but not adjourn it.

MR. GOLDBERG: And the Plaintiffs' position, after talking to Doctor Glover, is that he is tired. If this was all going to wrap up he would stay for another 45 minutes to 5:30. But it appears that it isn't. We are not making any agreements. We will try to see if we can work something out. He is going to Europe, as I told everybody.

MR. ROWLEY: We will attempt to schedule it after he returns from Europe, a scheduled resumption.

VIDEOGRAPHER: We're off the record.
(The deposition of ELBERT D. GLOVER, Ph.D. was suspended till further notice.)

STATE OF WEST VIRGINIA, To-wit:

I, Johnny Jay Jackson, a Notary Public and Registered Diplomate Reporter within and for the State aforesaid, duly commissioned and qualified, do hereby certify that the deposition of ELBERT D. GLOVER, Ph.D. was duly taken by me and before me at the time and place specified in the caption hereof.

I do further certify that said proceedings were correctly taken by me in stenotype notes, that the same were accurately transcribed out in full and true record of the testimony given by said witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which these proceedings were had, and further I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

My commission expires the 30th day of September 2004.

Given under my hand and seal this 4th day of October, 1999.

_____
Johnny Jay Jackson
Registered Diplomate Reporter
Notary Public